Hospital Management

A Practical Journal of Administration

DECEMBER 15, 1933

VOLUME XXXVI—NUMBER 6

¶ *Make 1934 a "Year of Education for Patients and Visitors* ¶ *Christmas in the Hospital* ¶ *How 20 Nurses May Save $4,000 a Year* ¶ *Factors in Influencing Bequests* ¶ *Pennsylvania Hospitals Help Win Relief Appropriation* ¶ *When Sea Sponges, Cotton Gloves were Used in Surgery* ¶ *Advantages of Central Food Service.*

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HOSPITAL MANAGEMENT

A Practical Journal of Administration

CONTENTS FOR DECEMBER

EVERY-MONTH FEATURES

BUYERS' GUIDE PAGE 4; INDEX TO ADVERTISERS PAGE 7

VOLUME XXXVI, NUMBER 6 DECEMBER 15, 1933

HOSPITAL MANAGEMENT, published on the fifteenth of each month at 537 South Dearborn Street, Chicago, by the Crain Publishing Company. Member Audit Bureau of Circulations, Member Associated Business Papers, Inc. Subscription, $2 a year. Single copies, 20 cents. Entered as second class matter May 14, 1917, at the post office, Chicago, Ill., under the act of March 3, 1879.

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Eastman Kodak Co.
General Electric X-Ray Corp.

INDEX TO ADVERTISERS

Some Letters to the Editor

Central Food Service

[Editor's Note: The accompanying is published in connection with the letters from Dr. Walsh and Mr. Bacon which appeared in the last issue on page 8.]

[Copy for Mr. Foley.]

Mr. Asa S. Bacon, Presbyterian Hospital, Chicago:

Dear Mr. Bacon: Thank you for the copy of your letter to Mr. Foley, commenting on my communication to him in reference to a squib in his magazine about central food service.

No one has been more outspoken in praise of your accomplishment with food service than I, and you are doubtless aware of this. Then, too, I am very much in favor of the application of a central system for food and supplies to those institutions where conditions make such service feasible and practicable. But what I most strenuously object to is the persistent misrepresentation of the applicability and alleged virtues of this system by certain individuals who seem to be totally blind to the possibilities and the proved value of other methods.

Certainly you will agree with me that in view of the food service problems confronting such a large proportion of our hospitals where the installation of a central system is impractical, it would have been helpful to the students attending the Seminar if there had been less emphasis on that one method and an attempt made to cover a wider field. This is not only my own view, but that of a considerable number of the students expressed during and since the Institute.

I certainly did not intend in my letter to Mr. Foley to intimate that you had made central service a hobby, nor that any blame should attach to you for the program. Indeed, it would have been incomplete without an exposition of the food system as carried on at the Presbyterian, and I was one who proposed its inclusion.

My plea is for accurate representations, truthful comparisons, and a disposition on the part of special advocates to play fair in the presentation of evidence. If these methods are pursued we may depend upon the intelligent hospital administrator choosing wisely.

With my kind personal regards, I remain,

Very sincerely yours,
William H. Walsh, M. D.

About That Program

[Editor's Note: The following are some comments received by Hospital Management in regard to the food service section of the 1933 institute on hospital administration of the A. H. A., which was the subject of an interchange of letters between Dr. Walsh and Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago.]

"Very well planned. Members of program gave most unbiased presentation of their subjects. Central food service was especially well presented. On future institute programs various methods of food service should be presented in the same unbiased manner; their merits to be determined by hospital superintendent to that degree in which they may solve individual hospital problems."—Charlotte F. Landt.

"It was a most practical program. Mr. Bacon can always be trusted to come through with tried and proven recommendations and this program was full of them."—M. W. Johnston.

"I think it was one of the best planned sections of the Institute. Was sorry that I could not attend all of the sessions."—Lula F. Martin.

"I was unable to take in all the food sections, but those I did attend were splendid."—Charles H. Dabbs.

"Fine."—Hugh A. Cooper.

"Very satisfactory—unusually well handled."—Lina McMahon.

Group Hospitalization

Editor, Hospital Management: Where can I get some concise, specific information in regard to group hospitalization? Or is it too much of an experiment yet? Have read several articles, the most concise one appearing in August Hospital Management. Have you any information about a small hospital, the only one for miles around, as to experience with group hospitalization? Reader.

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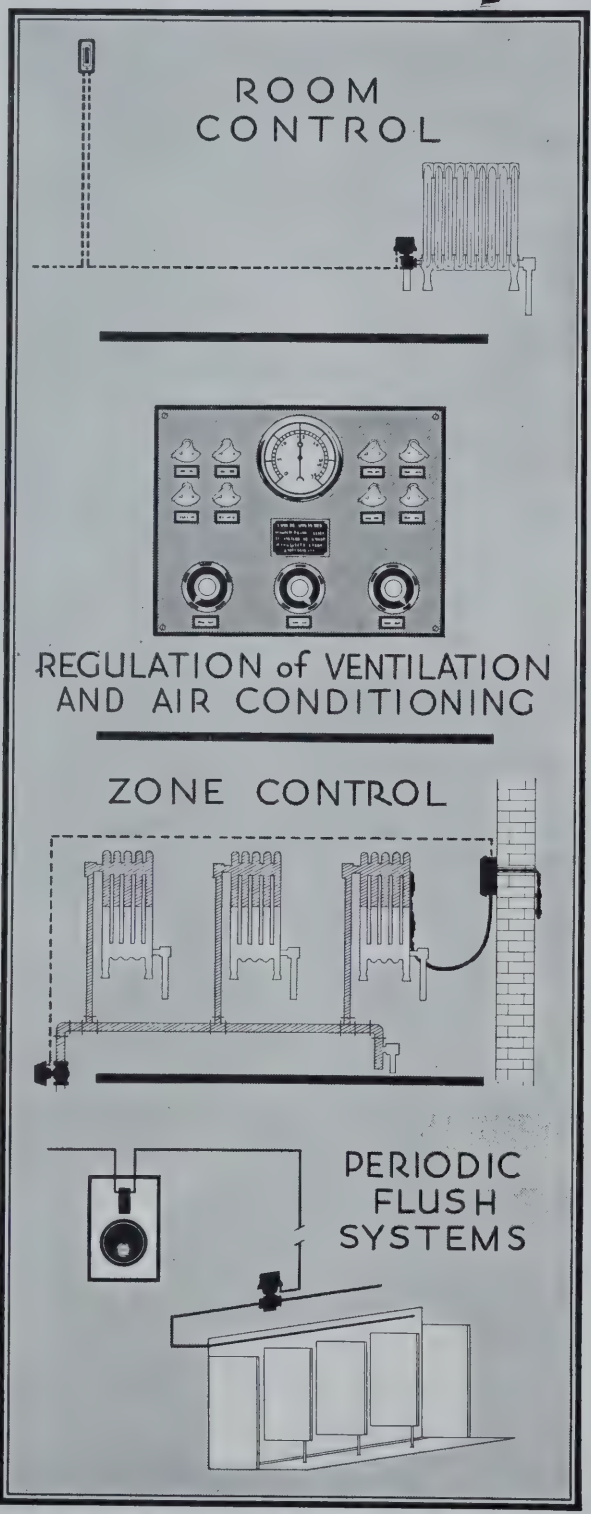

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Anaesthetics

No. 358, 359, 360. Booklets on "Spinal Anesthesia," "Obstetrical Analgesia" and "Open Ether Anesthesia," authoritatively prepared for the profession by E. R. Squibb & Sons. 233

Cubicle Equipment

No. 337. "Privacy in the Modern Hospital" is the title of a valuable booklet on cubicle screening published by H. L. Judd Co. After outlining the problems involved in securing privacy for ward patients, the booklet works out concrete solutions for many problems. c32

General Equipment, Furnishings and Supplies

No. 342. A table showing the amount of Lysol disinfectant and water necessary to make solutions of various strength, together with a description of the correct solutions to use for various purposes in the hospital. Also a dilution chart for use in the laundry. Lehn & Fink, Inc. 532

No. 261. "Nurses' Apparel and Hospital Supplies," a 32-page catalog. Marvin-Neitzel Corp.

No. 328. "Curity Ready Made Dressings Manual," an interesting manual showing the complete line of ready made dressings, with descriptions of uses and other informative material. Lewis Mfg. Co. L31.

No. 340. A complete series of pamphlets, many of which, such as "The Mystery of Sleep," "Why the Cat Unit?" and "When Chemists Turned from Gold to Drugs," are especially useful in teaching materia medica to student nurses. Available in any quantity. Hoffman-La Roche, Inc. 432

No. 376. "Wyandotte Products for Hospitals and Institutions" explains how all cleaning in the hospital and institution can be done, and how every rule of thorough, safe and economical cleaning can be easily followed. The J. B. Ford Co., Wyandotte, Mich. 1033

No. 354. Sterilizing technique for rubber gloves, and a description of the "Anode" process of glove manufacture. Massillon Rubber Co. 1033

No. 355. "Surgical Motion Pictures," a folder describing the pictures on clinical subjects available for loan to hospitals. Davis & Geck, Inc. 233

No. 356. "Alcohol Facts," a leaflet describing the various kinds of alcohol and related chemicals used in hospital work. Rossville Commercial Alcohol Corp. 233

No. 366. "Hospital Service Book and Catalog No. 1" has just been issued by Johnson & Johnson, containing editorial and catalog material about surgical dressings, sutures, etc.

No. 367. Free of charge regularly to any hospital executive interested in radiography, "Radiography and Clinical Photography," a magazine published by Eastman Kodak Co. 633

No. 368. The "White Knight" list of quality garments for all hospital purposes, as well as linens and blankets, with prices. Issued by Will Ross, Inc.. 733

No. 364. "The All-Wool Blanket," a booklet giving details of the manufacture and care of wool blankets, bedmaking, etc. Kenwood Mills. 433

No. 370-371. A card showing color samples of blankets, and (371) a card to hang in the laundry showing just how to launder all-wool blankets. Kenwood Mills.

No. 369. "Care of All-Wool Blankets," a detailed description of the methods of storing, laundering, cleaning and otherwise caring for wool blankets so as to keep them in good condition. Published by Kenwood Mills. 733

No. 372. A handsomely-illustrated booklet describing in detail Western Electric program distribution systems for hospitals. Graybar Electric Co. 833

No. 373. An authoritative discussion of cleaning problems, "Building Cleanliness Maintenance," in attractive form. Colgate-Palmolive-Peet Co. 833

No. 374. "The Sya-Vac," a non-mechanical evacuating apparatus, just introduced by the Scialytic Corp. 1033

No. 375. "Towels and Their Story," describing manufacture, care and selection of towels for all purposes. Cannon Mills. 1033

Kitchen and Food Service Equipment

No. 378. "Cutting Refrigeration Costs," a survey of refrigeration requirements for institutions prepared by Kelvinator. 1133

No. 379. A folder on "Econo-Rim," a new design in china for the purpose of saving tray and table space. 1133

No. 363. A booklet giving quantity and individual recipes and analyses of food values of bananas. Issued by the Editorial Department of the United Fruit Co. 433

No. 365. A handsomely printed 84-page booklet of descriptive and catalog information about cooking china, teapots, etc. Hall China Co. 433

No. 349. "Practical Planning for Hospital Food Service," a 62-page booklet published by the John Van Range Co., covering every detail of kitchen and food service planning and equipment. 1032.

No. 351. "Adobe Ware," a beautifully illustrated 12-page booklet describing the newest type of china for general and tray service. Onondaga Pottery Co. 1032.

No. 276. Modern Kitchens. A 70-page booklet. International Nickel Company. C30

No. 252. "Scientific Hospital Meal Distribution." Swartzbaugh Mfg. Co., Toledo, O.

Sutures and Ligatures

No. 322. "Handbook on Ligatures and Sutures," 1931 edition. An interesting booklet on the history, preparation, handling and use of ligatures and sutures, completely revised. Johnson & Johnson.

No. 361. "Manual of Surgical Sutures and Ligatures," a 56-page description of the manufacturing processes, uses and behavior of all kinds of sutures and ligatures. Published by Davis & Geck. 333

Sterilizers

No. 234. "American Sterilizers and Disinfectors." Catalog. American Sterilizer Company, Erie, Pa.

No. 213. "Sterilizing Technique Series." Five booklets. Wilmot Castle Company.

A Greeting and a Pledge

WITH sincere appreciation for the opportunity of serving you, we of The J. B. Ford Company earnestly hope that the joys of a very Merry Christmas will usher in for you a New Year that will more than fulfill your highest expectations.

Once again we pledge ourselves to a continuation of the policy established many years ago and which has met with your generous approval,—not only to supply you with the finest products, but also to render you every possible service and to observe the spirit as well as the letter of fair dealing.

Wyandotte PRODUCTS

The J. B. Ford Company

Wyandotte, Michigan

What Members of the Editorial Board Have to Say About:

"Merry Christmas!"

FOR patients able to be up, services are arranged Christmas Eve at the chapel with special program by nurses' chorus choir, congregational singing, and address. Patients in rooms are remembered with special plate of cakes, candies and fruit with a Christmas card and special Christmas favors.

For nurses a special evening at the Nurses' Home, with Christmas tree and gifts and program by nurses participating, is provided. The other hospital personnel have their special group celebration with their own Christmas tree and program. During Christmas Day four or five choruses or Christmas Carolers sing in the halls of the hospital.

The program in the chapel is adapted to the character of the Christmas service. The program in the Nurses' Home is arranged by each class taking two or three numbers, tableaus, dialogues or music.—Rev. H. L. FRITSCHEL.

AS the Christmas season is close at hand, the women's auxiliaries of our hospitals have a wonderful opportunity to make the holiday brighter for suffering humanity.

1. The ladies can see that the corridors and wards are properly decorated and Christmas trees installed, especially in the children's department. A tree in the main corridor adds Christmas cheer to the visitors.

2. A Christmas Eve program for the convalescent patients, doctors, nurses and employes, with Christmas tree and Santa Claus, which always brings cheer to the hospital.

3. On Christmas Day, music in the corridors, beginning with a nurses' chorus at 6 a. m. singing Christmas carols throughout the hospital, makes a happy day for the sick.

4. Then there is the Christmas dinner, with turkey and all the fixings for everybody. Presents for the children, and especially shoes, stockings, and warm clothing for the poor sick children. Warm clothing for the men and women in the wards is always needed.

5. Entertainment on Christmas night for the interns and nurses, all of which, or any part, can be sponsored by the ladies, and what a happy Christmas it is, "the Christmas in the hospital."—ASA S. BACON.

CHRISTMAS for the student nurse always has been treated as a very special occasion in this institution. The students who live out of town have the privilege of going to their homes over the holidays, as the students who live in town are able to go home over week-ends and over night. For those who do not go home, however, we make special plans, chief of which is a dance given some time between Christmas and New Year's. One day during the holidays, open house is held for the friends and relatives of the students.

The Nurses' Home, dining rooms, corridors, and auditorium are beautifully decorated with Christmas trees and greens for Christmas Eve. A party is given, and each student receives a gift from the large tree in the Auditorium. Nobody is overlooked, as days before, the names of all students, together with those of the nursing staff, are placed in a box. Drawings are held, and the students drawing a certain name buys a gift appropriate to that person. Much originality is shown in the selection of the gifts. We have stunts, games, songs, and refreshments, and act like any other children having a good time.

On Christmas morning, our Glee Club awakens us with the singing of carols.

The patient is not forgotten, as each receives a "Merry Christmas" in the morning, and the specially prepared dinner trays, made festive with a twig of holly, colored napkins, and favors appropriate to the season add much to the happiness of the day.

In our children's department, much planning is done beforehand. A beautifully trimmed Christmas tree is moved into the ward during the night, and the glass cubicles are decorated with many colored reindeers, Santa Clauses, and cotton snow. In the morning, after all the little patients have been attended to and convalescent patients rolled into the ward, Santa Claus, in the person of one of the doctors, appears with a huge pack of presents. Each child is called by name and receives not only one but sometimes two and three presents. This is a very happy occasion for all, as on this day the parents of these children are present. A movie show given on our own machine and screen closes the day for these little shut-ins. —WALTER E. LIST, M. D.

TO celebrate the Christmas season, evergreen trees are placed on each floor in the hospital, trimmed with electric lights, tinsel and other decorations, nurses and patients joining in this joyous and festive activity. Often patient, relative or nurse adds to the trimmings and so feels an individual interest in the trees.

On Christmas Eve it is the custom of a number of organizations to gather outside of the hospital to sing carols. This is climaxed early in the morning by the caroling of the members of the student body passing through the corridors carrying a lighted candle.

On the dinner trays, special place cards are used, a favorite one being a candle and holder of green gum drops, white life-savers for handles and red candles inserted. Candies tied in red cellophane with a sprig of holly add color.

A Christmas party for nurses and faculty comes the night before Christmas Eve, this night being chosen in order that there will be no interference for those who wish and can spend Christmas with relatives. Programs sponsored by the student body prove to be original, clever and enjoyable. After caroling early Christmas morning the nurses enter the dining room to breakfast in candle light. Dinner served to the entire groups except for relief nurses seated at the same hour provides a friendly atmosphere and spirit for those who must remain at their post to care for the sick.

Another party which radiates love and sympathy at the holiday season is one sponsored by the Orthopedic Society with the assistance of those in the physical therapy department. Handicapped children take part in the program, moving pictures are shown, huge baskets of gifts, fruit and candy are given to the children, and refreshments served.—C. J. CUMMINGS.

AD-venturing . . . . . .

Photographic records are easy and inexpensive to make with the Eastman Clinical Camera Outfit. Without special knowledge of photography, excellent detailed pictures can be obtained. The outfit also includes two backs designed particularly for producing lantern slides and enlargements. With the Eastman Clinical Camera Outfit your case records can be made of the greatest value to your staff—complete, illustrated, clear at a glance. Page 47.

* * *

First proclaimed by Dr. J. T. Gwathmey in 1923, ether-oil analgesia is rapidly becoming the method of choice for the relief of labor pain. In over 90 per cent of cases it produces satisfactory analgesia. In addition, it is economical—requires little equipment, and experience—is easy to administer in the home or hospital, and may be started in any stage of labor. It relaxes the perineum and increases the second stage of labor without danger to mother or child. Page 16.

* * *

Music in every private room and ward—via Western Electric Program Distribution System—brightens the dull hours of convalescence, helps patients to get well sooner. This system picks up speech or music—amplifies it—delivers it through loud speakers in private rooms and individual headsets in wards. Source of programs may be visiting entertainers, phonograph records or radio broadcasts. This equipment also handles "Doctors' Paging" quietly, instantaneously throughout the hospital. Whether your hospital is large or small, Western Electric—maker of Bell Telephones—can supply highest quality equipment at the right price. Page 45.

* * *

Just hand your prospective students the order blanks which we are glad to furnish and we will take the rest of the responsibility from your shoulders. You won't have to worry about telling your probationers how to make their outfits—it will not be necessary for you to collect any money or to keep any special accounts—and you can be sure that when your class enters it will be correctly and carefully outfitted. This special order service is worth a great deal to you, although it costs you nothing. Third Cover.

* * *

Ethicon Non-Boilable Catgut Sutures are produced in our own special laboratory in the packing house district of Chicago, where each day's supply of sheep's intestines is delivered to us fresh and in prime condition. The Johnson and Johnson suture laboratory is the only one especially located and built for the purpose. Every step of manufacture is carried out under strict laboratory conditions, from the receipt of the fresh intestines until the finished suture material is sent to our laboratories in New Brunswick for testing, tubing and sterilization. Ethicon Sutures are unusually strong and extremely pliable, uniform in size and heat-sterilized. They are ready to use upon breaking the tube—they require no soaking or other conditioning. Page 68.

* * *

"We are using Kenwood blankets at Sanatorium Gabriels and we find them most satisfactory. We prefer them to any other blankets." Send for Color Swatch Card. Page 6.

* * *

Diack controls fuse only under definite sterilizing conditions. For more than 12 years the choice of America's leading hospitals. Page 66.

* * *

See what a big margin of safety Monel Metal gives new American sterilizer. Since these sterilizers operate under pressure and are used by nurses — not mechanics — unusual strength is needed. For the first time American sterilizers through the use of Monel Metal provides this unusual strength—50 per cent greater than former standards of safety. Page 53.

* * *

When yellow with green tips, cook bananas as a vegetable. They make a delicious meat accompaniment. When yellow ripe, with no green on the tip, they're an excellent fruit for salads and desserts, and if still firm may also be used for cooking. When yellow flecked with brown, they're at their best to peel and eat—or combine with milk for a well-balanced breakfast, lunch, supper, or in-between meal. It is at this stage of ripeness that doctors recommend bananas for infant feeding. Send coupon for interesting, readable booklet, written by a physician and giving the newest banana health facts. Page 55.

* * *

You can effect a saving on scissors, too! A large New York hospital tells us that since using Bard-Parker Renewable Edge scissors they have effected a definite saving on scissor regrinding and replacements. The reason is simple, Bard-Parker scissors eliminate regrinding. Dulled edges may be replaced with new sharp edges at the low cost of 16⅔ cents per pair. Since the scissors are not worn out by grinding they last far longer than other scissors. Furthermore, they may be kept in constant use reducing the quantity of scissors formerly needed to replace those being reground. Because of their uniform sharpness, Bard-Parker scissors will be welcomed by the surgeon. Page 1.

* * *

It's a long stride from the conventional type of high voltage x-ray apparatus and this, reaching a new threshold in the design of equipment for deep therapy. The Coolidge tube is not operated in air as heretofore, but is immersed in oil and sealed within its grounded container. This, together with the use of insulated cables from the high tension transformer, makes the equipment 100% electrically safe and shock proof, and insures more stable operating conditions at considerably increased energy ratings, independent of atmospheric conditions. Page 59.

* * *

Supply your patients with Palmolive. In spite of its prestige it costs no more than ordinary soaps! We will gladly send you, upon request, a copy of our new free booklet and prices of Palmolive in five special sizes. Your hospital's name on the wrappers with orders of 1,000 cakes or more. Page 63.

* * *

With lots of hope and a few doubts we launched, last month, a new China-Econo-Rim—a china that defies all pottery tradition. A china that takes the emphasis away from the pattern and puts it on the practical basis of space - saving - money - making design. Since our announcement, Econo-Rim has had a thorough going over in the hands of hotel, restaurant, hospital, school and cafeteria people. Page 51.

* * *

How long is White? In cotton and gauze products, this is a practical question. All too frequently in the past sterilization or sunlight, or both, have set up a reaction with the chemical residues left from ordinary bleaching methods to cause undesirable discoloration. The white of ordinary gauze and cotton products is a very transient white, indeed. The new Bay bleaching process gives you gauze and cotton products free from chemical residues—products that are white when you get them, with a white that stays white. A white that is unaffected by sterilization or sunlight. Moreover, the original strength of the fibres is retained. Page 2.

"It's a Humdinger!" Says Mr. Jolly

AMONG the comments made by those who have ordered copies of HANDBOOK OF HOSPITAL MANAGEMENT by Matthew O. Foley, editorial director, "Hospital Management," are the following:

"It is a humdinger!"—ROBERT JOLLY, *Memorial Hospital, Houston, Tex.*

"Send me four more copies."—PAUL H. FESLER, *Wesley Memorial Hospital, Chicago.*

"Nowhere under one cover has one yet found so much that is imperative to know about managing a hospital. It will be a godsend to the superintendent who has to get over salient points to staff physicians, board members and her inside staff." (Ordered five more after seeing first copy.)—CHARLOTTE JANES GARRISON, *Memorial Hospital, Newton, N. J.*

"Most helpful to me. I shall be glad to recommend it at every opportunity."—SISTER M. FRANCIS DE SALES, *Misericordia Hospital, Philadelphia.*

"Of great benefit, particularly to the small hospital."—EDNA D. PRICE, *Emerson Hospital, Concord, Mass.*

"Mail me an additional copy at once." (Five ordered previously.)—DR. J. H. STEPHENSON, *Dallas City-County Hospital System, Dallas, Tex.*

"I mentioned it today in writing to two hospital superintendents, lest they might miss it."—SISTER M. CONCHESSA, *College of St. Catherine, St. Paul.*

"Meets a long felt need. Every hospital should have a copy for reference."—DR. CHARLES E. REMY, *Minneapolis General Hospital.*

"Your book is fine. Here's a check for $2 for my copy and for an extra book to go to St. Mary Hospital, Kankakee, Ill."—SISTER ST. JOHN, *Mercy Hospital, Urbana, Ill.*

"In sending a check for two Handbooks let me congratulate you on this splendid reference work . . . extremely valuable."—HOWARD E. BISHOP, *Robert Packer Hospital, Sayre, Pa.*

"An intelligent and orderly compilation of information. Send me five more copies."—CHARLES LEE, *Homeopathic Hospital, East Orange, N. J.*

"Should save busy people much time and effort."—MARY M. ROBERTS *R. N., Editor, The American Journal of Nursing.*

"I like the way it is gotten up; it is a very fine ready reference to have on one's desk."—SISTER JOHN GABRIEL, *Educational Director, Sisters of Charity of Providence.*

"Saw a Handbook today at the Portsmouth Hospital. Here is a dollar. Send me a copy by return mail."—MRS. JAMES B. REMICK, *President, New Hampshire Memorial Hospital, Concord, N. H.*

"Most helpful as well as informative."—ANNA C. M. NELSON, *Assistant Superintendent, Hospital, Jamaica, N. Y.*

(Photo by LaVeccha)

Matthew O. Foley, author of the Handbook of Hospital Management, for 14 years has been editorial director of "Hospital Management." The Handbook reflects this background and experience. Orders for extra copies for trustees, staff officers and others are best proof of the way the Handbook has been received.

"It is splendid. Here's three dollars. Please send the extra copies to the names enclosed and enclose my card in each."—MARGARET A. ROGERS, *Children's Hospital, Detroit.*

"Worth having." (After paying for extra copy.)—MARGARET R. PARKER, *Epworth Hospital, South Bend.*

"Our copies have been put in our reference library for student or graduate nurses interested in hospital management. I believe your book might fill a valuable place in hospitals giving post-graduate courses in hospital management. It certainly would be valuable for student nurses were it not for the fact that the curriculum in most schools is already so loaded."—ELIZABETH A. GREENER, *Superintendent of Nurses, Mt. Sinai Hospital, New York.*

"The book is a 'masterpiece'."—DR. B. W. BLACK, *Highland Hospital, Oakland.*

"Besides the two Handbooks we're using at the hospital, send me nine more for members of the executive committee."—EDWARD ROWLANDS, *Martha Washington Hospital, Chicago.*

"I am so delighted with the Handbook I feel you should know what a splendid contribution you have made to the hospitals. I am ordering three more copies, one for the president of the men's board, and two for the women's board."—MABEL W. BINNER, *Children's Memorial Hospital, Chicago.*

"Well pleased with contents. Feel it will benefit us greatly in our work."—SISTER M. PASCALINE, *St. Joseph Hospital, Kansas City.*

"Very good, practical, and to the point."—SISTER M. HILDA, *St. Bernard's Hospital, Jonesboro, Ark.*

"The twelve Handbooks were received with great interest by members of the board. However, we have none for the office. Kindly send two more."—R. A. NETTLETON, *Iowa Methodist Hospital, Des Moines.*

"A valuable bibliography on hospital administration."—THE CANADIAN NURSE.

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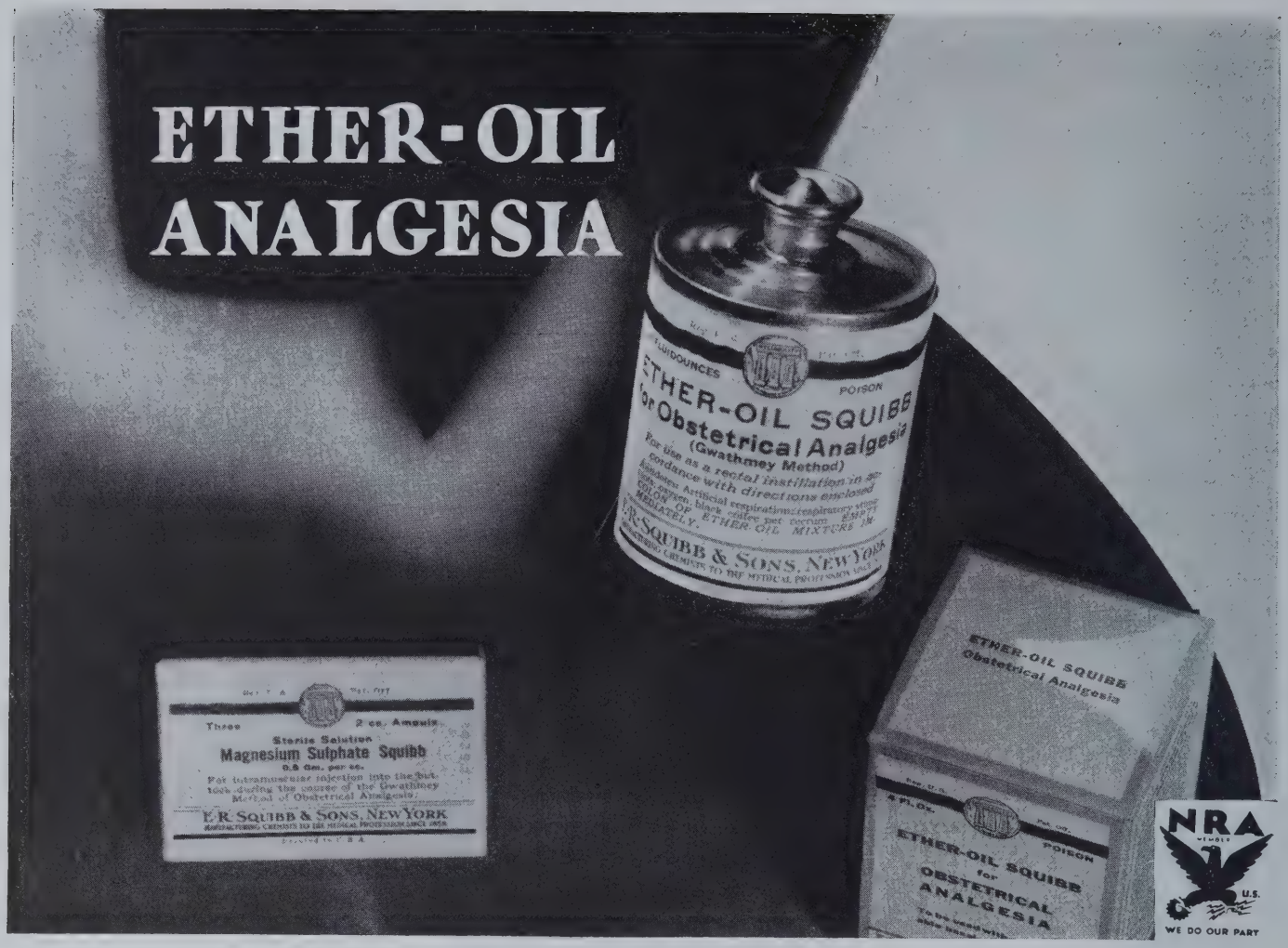

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Ether-Oil Squibb is made with Squibb Ether and Squibb Liquid Petrolatum—two products of outstanding quality. It can be given with magnesium sulphate according to Gwathmey technique, or with any suitable basal anesthetic agent. It is marketed in 4-oz. tins and also in packages containing, in addition, three 2-cc. ampuls of a 50% solution of magnesium sulphate.

For further information about Ether-Oil Squibb mail the coupon below.

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HOSPITAL MANAGEMENT

A Practical Journal of Administration

A Sure, Easy Way to Win Friends For Your Hospital in '34

Make 1934 a Year of Education of Patients and Visitors, Says "Hospital Management"; Here's a Simple, Low Cost, Effective Program That Will Benefit Every Hospital

By MATTHEW O. FOLEY

"MAKE 1934 a year of education for hospital patients and visitors."

HOSPITAL MANAGEMENT offers this suggestion to the field for the coming twelve months for the following reasons:

Never before has there been greater need for intelligent and generous cooperation and support from the public, from civil authorities as well as from citizens, organizations, professions and all groups. Economic conditions have materially increased free and part-free patients, decreased full pay patients, reduced donations and bequests, and resulted in material curtailment of support from public funds. In fact, as far as government authorities are concerned, efforts to tax hospitals, even though they are non-profit in operation, are feared in different sections.

Few hospitals utilize the opportunity for informing patients and visitors regarding hospital problems to the extent to which these opportunities are available. Experienced hospital superintendents appreciate that the "satisfied patient is the best advertisement," but in most instances no effort is made to make the patient understand how he has been satisfied.

With more than 7,000,000 in-patients to be admitted during 1934, and with more than 8,000,000 out-patients treated, the hospitals will have right in their own institutions some 15,000,000 individuals, the great majority of whom undoubtedly could be made firm and lasting friends of hospitals if a systematic effort were planned and carried out in 1934.

An Easy, Sure Way To Win More Friends

This is an article of special importance to every hospital which realizes the need for more active interest and support of the public.

It suggests an easy, inexpensive, certain way to win more friends and to develop a source of intelligent support for the hospital in the community.

Briefly, here's the idea: Every patient and visitor to your hospital is a prospective friend. Most of them can be made real, active friends, if a simple effort to do this is made.

This article suggests a simple way to create better understanding of your hospital, without interfering in any way with hospital routine.

The big question is: Will your hospital accept this suggestion?

It promises success, it is convenient, inexpensive, and best of all, it can be put into effect by nearly every hospital, without reference to what other hospitals in the area may do.

Suppose that the average in-patient received only five visitors during his or her stay in the hospital—that would mean another 35,000,000 individuals coming right into the hospital within range of the educational program. Counting the visitors to the in-patients, and the in- and out-patients, the hospitals' educational program in 1934 would contact 50,000,000 people, or two out of every five people in the United States, on an average.

Even if only half, or a third, of these 50,000,000 people actually were reached by an educational program, the result would be wholly worth while. An outline of beneficial results would require many columns, but among the principal benefits would be listed:

Prompter payment of bills because of a better understanding of the hospital's operation.

A greater patronage of hospitals by the public.

Readier assent to visiting hours and other rules for visitors.

Fewer criticisms of hospitals by word-of-mouth after the patient has gone home. (This is recognized as one of the most disastrous results of misunderstanding or lack of information by patient or visitor.)

A more sympathetic attitude on the part of newspapers and publications, speakers, organizations, etc., as a result of their own better understanding of the hospital or of the better understanding of reporters, individuals, club members, etc.

More consideration for the hospital from local or county or state officials in connection with payment for service to indigents, etc.

A more willing reception of appeals of hospitals for donations and bequests.

A Practical Way to Win More Friends for Your Hospital

Practically every hospital can definitely add to the number of its interested and active friends if it will make just a little effort to do this, and continue this effort for a definite length of time.

HOSPITAL MANAGEMENT *suggests that the year 1934 be made a "year of education for hospital patients and visitors" and further suggests that this education be carried on by the use of leaflets, bulletins and posters. This material is readily available at low cost and this plan of education may be used without interruption of any feature of hospital routine. It does not call for special qualifications for the superintendent or other person, such as is required for a talk before a club, an article in the newspapers, etc.*

By concentrating on patients and visitors hospitals will make sure that they are contacting people who for some time during the year are personally interested in the hospital. The patient is vitally interested in being restored to health, the visitor is interested in having the friend or relative well again. So if a hospital will make even the little effort suggested in this article it will create new friends and it will gain some of the other numerous benefits outlined in the article.

HOSPITAL MANAGEMENT *firmly believes that every hospital which will enlist in this "year of education" will definitely profit by it.*

We are anxious to know how many hospitals will join this movement and we stand ready to offer suggestions and advice in regard to the movement.

Other benefits from a well informed public will readily come to mind.

And how may this educational program best be carried on?

HOSPITAL MANAGEMENT urges each hospital to undertake its own program, with its own patients and visitors. In this way immediate results will be gained right in the home community of the hospital. Of course, local, state, sectional and national associations ought to cooperate as much as possible, but the most effective work can be done only by the individual hospital.

What of the expense?

HOSPITAL MANAGEMENT believes that each hospital may do effective educational work among patients and visitors at very nominal expense—negligible cost in time and money when the space of one year is considered. Incidentally, every hospital entering into this educational program should resolve to carry on for one year. To start a program and quit at the end of a month or a few months is practically a waste of time.

The program contemplated by HOSPITAL MANAGEMENT is simple and inexpensive. We believe it is well within the possibilities and pocketbooks of the great majority of hospitals. It may be carried on without interruption or rearrangement of present routine. Of greatest importance, materials necessary are available at low cost and prepared with expert touch as well as with knowledge of the limitations of ethical hospital publicity.

The foundation of this year of education for patients and visitors is:

Information leaflets for patients. To be made available on admission or at the attending physicians' offices, with extra copies always on hand in the patient's room, for use of visitors.

Posters, to be placed in waiting rooms, lobbies, elevators, and in public spaces of the hospital.

A hospital bulletin, quarterly or of more frequent publication, to be distributed to patients and to visitors.

HOSPITAL MANAGEMENT recommends the leaflets, posters and bulletins as a practical foundation for a successful year's educational program of patients and visitors.

As stated, these materials may be obtained at low cost, edited or presented in expert fashion and at the same time in keeping with hospital publicity ethics.

HOSPITAL MANAGEMENT emphasizes the point that there is little originality in these suggestions, which some hospitals are carrying out with good effect and have been carrying out for several years. But the great majority of hospitals have not even such a simple, inexpensive and most effective educational program in operation, and to this great group of hospitals the suggestions for a year of education for patients and visitors are submitted with full confidence that every hospital which undertakes such a program for twelve months will be wholly satisfied with it.

MATERNITY STANDARDS

That national organizations concerned in hospital management unite on a set of minimal standards for maternity service, and that hospitals not accepting these standards be forbidden to accept this type of patient was suggested at the 1933 American Hosptial Association convention in a paper on "The Obstetric Problem of the Small Hospital," by Dr. A. J. Skeel, director, division of obstetrics, St. Luke's Hospital, Cleveland.

Dr. Skeel said that such action would help the hospital superintendent obtain the necessary funds for remedying poor physical conditions in the maternity department, if these existed, and that they also would help to correct deficiencies in staff organization and give him a foundation upon which to recommend necessary changes or improvements.

Dr. Skeel advocated unified housing of the obstetrical division, that is, that the labor room, delivery room, nursing and rooms for patients be immediately adjacent to one another with no intervening space used for other purposes.

The speaker also pointed out that conditions safe for general surgery are not safe for obstetrics and that the obstetrical department requires proper staff organization, physical segregation of the unit, and administrative isolation of the unit. He also advocated an effective licensing system for hospitals offering maternity service, frequent inspection, and provision for expert advice on technical problems.

DR. MOOTS IS DEAD

Hospital people of the west coast and those who attend the hospital conferences of the American College of Surgeons regularly will learn with regret of the death of Dr. C. W. Moots, for a number of years a visitor for the American College of Surgeons. Dr. Moots won a host of friends by his genial personality, his spirit of helpfulness, and by his untiring efforts to aid in the solution of problems. For a number of years he was visitor among hospitals in the far western states and western Canadian provinces. As was his custom, he was motoring to the annual conference of the College when illness forced him to enter a hospital. Dr. Moots for many years was chief of staff of Lucas County Hospital, Toledo, O., and later founded the Toledo Clinic. His studies of surgical risks won him a reputation in that field. During the war Dr. Moots was commanding officer of a naval hospital and at one time was chief medical officer of the naval hospital ship, "Mercy."

Some Typical Christmas Programs

(Courtesy Hackensack Hospital)

Hospitals are busy with plans for their Christmas programs these days, and despite economic and other hardships, personnel of every institution look forward to providing a day of pleasure and entertainment for patients and their co-workers.

Here are three brief outlines selected at random indicating how many hospitals will celebrate Christmas:

HACKENSACK, N. J., HOSPITAL

"The Christmas spirit pervades every nook and corner of the Hackensack Hospital during the holiday season. Decorations and entertainment are provided by the Woman's Auxiliary, through the generosity of the auxiliary, interested friends and organizations in the community and the branches of the auxiliary.

"Preceding Christmas Day a dinner is given for the nurses and staff of the hospital in the evening, which is looked forward to by all the family.

"Trees are provided for the wards, dispensary and clinics, and on Christmas morning Santa Claus visits the patients, presenting them with an orange or apple, while student nurses sing carols in the corridors. A most appetizing dinner is served on Christmas Day. Carolers from churches and organizations visit the hospital during Christmas week, up until the New Year, all contributing their talents toward making the Yuletide a happy one in the hospital."

HAHNEMANN HOSPITAL, PHILADELPHIA

"Weeks of preparation precede the annual visit of Santa Claus to Hahnemann Hospital, when toys and gifts are distributed to every child in the institution. Members of the board of trustees, nurses, physicians, and women's organizations combine to make Christmas Day most cheerful for all in the hospital.

"The celebration centers in the children's ward, where a Yule tree is always erected, surrounded by a miniature village with electric train and other mechanical aids to gladden the hearts of boys and girls.

"Stacks of packages, tied with bright ribbon, are piled beneath the decorated tree and the children each year walk or are wheeled into the room set aside for the celebration to receive their gifts.

"Wide-eyed and expectant, the little patients are confronted with the brilliantly lighted tree and Santa Claus is always there to greet them and pass out individual presents. An intern usually is selected to play the part of Kris Kringle in frequent appearances in the ward throughout the day.

"Gifts to staff physicians, nurses and other hospital workers usually are distributed after the children are busy with their toys, and time-honored customs of Christmas are observed in the exchange.

"Preliminary trips through the wards are made by nurses and men and women interested in the welfare of the patients and their needs are classified. Suitable clothing is frequently found in the Christmas stocking of needy boy and girl patients ready to be discharged.

"The children are canvassed some days in advance of the great day and in every case, wherever possible, the choice of presents asked for is found with the little patient's name attached.

"Besides the original gifts, purchased by some member of the hospital staff from a list provided, other toys are handed around. There is always more than enough toys, books and other gifts donated to provide every child with plenty of playthings.

"Each room and ward is decorated. A long string of visitors passes into the institution throughout the day with gifts and there is a profusion of baskets of fruits, flowers and carefully wrapped packages.

"To bed patients who cannot be moved the gifts are carried and miniature trees set up beside them. The same procedure is followed in isolation wards."

WESLEY HOSPITAL, CHICAGO

"Who says there is no Santa Claus? Come with me to Wesley Memorial Hospital so that I can show you the sick kiddies and the grown-up patients who still feel that there could be no Christmas without Santa Claus.

"First let us visit the large ward on the sixth floor of the hospital. See the beautifully trimmed tree, laden with gifts for children and grown-up patients. They have assembled here this afternoon to listen to a special program and to await the arrival of Santa Claus.

"After the invocation by the hospital chaplain, the Nurses' Chorus is heard. This is followed with an address of welcome by George W. Dixon, president of the hospital. He has been introduced by Paul H. Fesler, superintendent. Next is a solo, then a reading by members of one of our leading Chicago churches. The har-

monica band, from one of the high schools, begins playing 'Jingle Bells,' and everyone looks expectantly at the door, for they feel that it soon will be time for Santa Claus to put in his appearance. Just as the last word of the benediction is pronounced we hear jingling of the sleigh bells. Old Santa has pulled up his reindeers, unloaded his sled, and now he is heard coming down the corridor, joyously shouting, 'Merry Christmas to all!'

"Now for the presents and stockings that are filled with candy, nuts and apples. What joy there is everywhere, for Old Kris Kringle hasn't forgotten anyone! As soon as he is through here, he goes to visit every patient who was unable to attend the exercises, leaving with them a Christmas stocking.

"Can you spare a little more time some other day this week? If so, come with me to the children's ward, for there is to be another tree and program.

"The kindergarten teacher and the supervisor of this department have planned a delightful program, decorated a tree, and wrapped gifts for every little patient. On this day former patients return, for they have been told that Santa Claus is expecting them and in his pack is a gift for every returned patient.

"How busy these tots have been during the past week writing their letters to Toyland, and today they can hardly wait until Santa arrives. This time he is coming down the fire escape and through the open window, with his heavily laden pack on his back. He visits every child, calling each by name, and is more than repaid for his visit with the thanks he gets.

"Members of the Woman's Auxiliary have been so kind and thoughtful. Through their churches, gifts have been sent to the children's department so there will be enough gifts to put in the stockings which will be hung Christmas Eve. You see, Santa preferred not to give all the gifts the day of the Christmas tree, which had to be held a few days before Christmas.

"The nurses and hospital personnel have a tree either at the Nurses' Home or Hardin Square. After a short program, dancing and refreshments follow. Friends are invited to this party.

"You see that through the efforts of the president of the Board, Woman's Auxiliary, the hospital superintendent, and the director of the School of Nursing, the spirit of Santa Claus in this institution can never die."

(Courtesy Hahnemann Hospital)

Kansas Meeting Is Well Attended

The nineteenth annual meeting of the Kansas Hospital Association at Eldorado, October 28, opened with an attendance of 65, the largest in history. John E. Lander, financial secretary of Wesley Hospital, Wichita, president, in his address suggested the division of the state into sections to facilitate the work of enrolling new members and also to assist the legislative committee. He stressed the importance of watching proposed legislation and of sponsoring needed bills, mentioning the new Ohio law which provides that a portion of license fees be set aside to help pay for hospitalization of automobile accident victims.

Mr. Lander was re-elected president, the other officers being:

First vice-president—Sister Madeline, Mercy Hospital, Independence.

Second vice-president—C. Blanche Duncan, McPherson; third vice-president, Bertha Hubacher, Ottawa.

Executive committee — Norman Rimes, Topeka; Dr. L. D. Johnson, Chanute; H. E. Suderman, Newton.

Those who participated in the program included Ethel Hastings, Bethany Hospital, Kansas City; Norman Rimes, Christ's Hospital, Topeka; Dr. A. R. Hatcher, Wellington; Sister M. Stella, Wichita Hospital; Theresia Norberg, Beloit; Bertha Hubacher, Ransom Memorial Hospital, Ottawa; Mrs. Beulah Davis, Axtell Christian Hospital, Newton; Judge Geo. J. Benson, Eldorado; Mrs. Kistler, Allen Memorial Woman's Auxiliary; Mrs. H. E. Suderman, Bethel Hospital Auxiliary, Newton.

As was to be expected, financial and economical problems attracted the greatest attention and featured round tables and other discussions.

President Lander was requested to remain as chairman of the legislative committee and he acceded to this request, appointing Dr. Hatcher, Dr. L. D. Johnson, Mrs. Rodeen and Sister Alphonsus to serve with him.

Another feature of the convention was a very splendid historical sketch of the organization, prepared by Dr. J. T. Axtell, founder of the association.

Illinois Sales Tax Rule Modified

Through the efforts of the Hospital Association of Illinois, in conjunction with the Chicago Hospital Association, an amplification of the ruling of the department of finance in regard to the application of Illinois state sales tax to hospitals recently was obtained. Under the previous ruling it was asserted that hospitals would have to pay a tax on meals furnished personnel and also on X-ray service. The amplified ruling is:

Hospitals, infirmaries, sanitaria and like institutions are engaged primarily in the business of rendering services. They are not liable for Retailers' Occupation Tax with respect to their gross receipts from meals, bandages, dressings, drugs, X-ray plates, or other tangible personal property, where such items of tangible property are used in the rendering of hospital service. This is true irrespective of whether or not such tangible items are billed separately to the patient. Hospitals, infirmaries and sanitaria are deemed to be the purchasers for use or consumption of such tangible personal property and the seller of these items to hospitals, infirmaries or sanitaria is liable for payment of the Retailers' Occupation Tax with respect to his receipts therefrom.

Where a hospital operates a dining room, or a pharmaceutical dispensary, or otherwise sells tangible personal property to consumers or users apart from the rendering of hospital service, and for which it makes a specific charge, it then becomes liable for payment of the Illinois Retailers' Occupation Tax.

Where meals are served to nurses, attendants, and patients of the hospital as a part of the service rendered in conducting the institution, the hospital, infirmary or sanitarium is deemed to be the user or consumer of all food and beverages products used in the preparation of these meals.

Credit for the amplification of this ruling is due in great measure to C. J. Hassenauer, superintendent, Garfield Park Community Hospital, Chicago, chairman of the legislative committee of the Chicago Hospital Association; Paul H. Fesler, Wesley Memorial Hospital, chairman of the state legislative committee; Rev. J. W. Barrett, diocesan director of the Catholic Hospitals of Chicago; Maurice Dubin, Mt. Sinai Hospital, Chicago, secretary of the Hospital Association of Illinois, and Clarence H. Baum, Danville, president of the state association.

How 20 Nurses May Save a Hospital Minimum of $4,234 in Year

Outline of Daily Routine of a Nurse Suggests Many Opportunities for Economy That Also Mean Better Service and Greater Satisfaction for the Patient

By SISTER CYRIL

Director, Seton School of Nursing, Colorado Springs, Colo.

IN this age of transition and depression the question that is vital and paramount in the minds of financiers, educators, and professional people is economy, whether it be economy of money, of time, or of procedure.

In our hospitals this problem of economy is a matter of concern to various groups of people. First, there are those for whom the hospital exists, the patients; second, those who are caring for the patients, such as doctors and nurses; and in the third group we include the remainder of hospital personnel. In this paper it is my purpose to deal with a part of the second class, namely, the nurses, and to call attention to a few typical instances in which economies can be practiced by them without lessening the care or comfort of the patient.

Good nursing is closely related to good housekeeping. Hence, early in her education, the nurse should be taught the value of equipment and the necessity of keeping it in good condition, as well as the method of using hospital supplies to the best possible advantage. There must be developed in her a sympathy and an interest in the economic problems of hospital management, and a spirit of whole-hearted cooperation with the hospital staff in these matters, also a conviction that the welfare of the institution depends in large measure upon this spirit of cooperation.

There are many ways in which a careful nurse can practice economy, and they will usually add to the comfort of her patient rather than detract from it. The young woman who has had to face the difficulty of making ends meet in her own home will have a sympathetic understanding of the household problems in hospital administration and will do all in her power to eliminate unnecessary costs.

Let us accompany a conscientious nurse in her daily rounds, and note the opportunities which she uses to prevent waste and destruction. She begins practicing economy in her own room, for she takes care that the window is closed whenever she leaves for any length of time. Snow and rain destroy window sills and polished furniture. Electricity burns hospital money, and so she puts out her light with promptitude. As she goes on duty, she notices along the corridor lights b u r n i n g unnecessarily and makes it a point to put them out. Several patients, too, have lights they do not need. With a cheery "Good morning," she enters their rooms, raises the curtains, and turns out the lights. One patient calls her attention to a leaky radiator. She promptly reports this to the head nurse. An early repair prevents a ruined floor and ceiling. It is now time to prepare the breakfast tray. Here our nurse is careful to make the tray attractive and to serve only those foods, and the amount of them, which she is sure the patient will eat. She removes the butter from some trays, since these patients do not use it for the morning meal. Is she neglecting her patients in thus omitting from their trays those items of food which she had learned they do not like? Not at all! Indeed, experience has taught her that undesired food persistently served is an annoyance and often tends by its unattractiveness to the individual taste to lessen a patient's appetite for other dishes.

When preparing for the bath and morning care, precaution is used to protect the table from soap and alcohol. How little effort is required for such care, and yet the lack of it may ruin a good piece of furniture. Use of linen is her next careful consideration. The special who changes the entire bed twice a day does not add to the patient's comfort, but does add considerably to the hospital costs, both in the laundry and in the deterioration of material produced by unnecessary washing. Most hospitals supply daily one each of the following: sheet, draw sheet, pillow case, bath towel, face towel, and washcloth, and under ordinary circumstances this is ample for comfort. Anticipation and close observation at regular intervals in involuntary patients; the careful use of rubber sheets, pillows and pads; the prevention of stains by cautious administration of medicines; and the immediate removal of unavoidable stains are but a few of the precautions which our thoughtful nurse will exercise. The linens that are used injudiciously to dust or wipe up spilled material as well as stained linens are always objectionable and necessitate a new supply, resulting in an uncalled for extravagance.

The phone rings. She answers and receives a message for the head nurse. She is tempted to write the message on a piece of paper before her, but just as she begins to do so she notices that it is a piece of graphic chart paper, the cost of which is a cent and a half per sheet. So she uses, instead, the scratch pad provided for that purpose. She then goes to the service room to care for the utensils she has been using, drying them thoroughly to prevent destructive rust and stains. The sterilizers, expensive hospital equipment, are important objects of interest. She makes sure that there are no possibilities of their boiling dry; instruments and other equipment are given proper care and prepared for sterilization in the autoclave. Bacteriologists today tell us this is the safest and best method. Dry sterilization also prevents such accidents as burning catheters and rubber tubing and the breaking of glassware.

Two dripping faucets attract attention. One she turns off tightly; the other needs repair, and she reports it at once, for dripping faucets increase water bills. She recalls an incident in which two gallons of water was collected in a few hours from a dripping faucet.

Assisting the doctor with surgical

dressings is the next duty which awaits her. She uses only the amount needed, preventing unnecessary waste. The extravagant use of gauze readily runs up into money. With forethought she has prepared special dressings for drainage cases and has the adhesive in lengths ready for use. So much waste is caused when strips are longer than is necessary. In making up solutions, too, she is careful to prepare only the required amount.

As she prepares the midday meal, and indeed in all serving of trays, the same precaution is observed as at breakfast, and amounts are measured in accordance with the patient's needs and desires. She remembers two of the patients who do not like the dessert on the day's menu. If it is served it will just be returned and wasted. Accordingly she prepares from fruit she has on hand some little thing that will satisfy the sick persons and prevent waste. Of course, there is no intent of denying anyone what he needs, nor on the other hand of encouraging foolish and extravagant whims, but little acts of practical thoughtfulness contribute greatly to the happiness of patients as well as to good management.

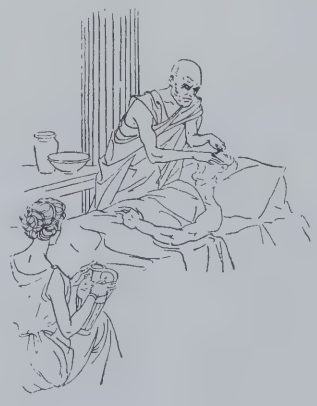
During the afternoon, we need scarcely say, the good nurse practices the same economy in all her procedures. When patients are permitted up in wheel chairs, she uses blankets provided for that purpose in order to save the better ones on the beds. She supplies ash trays where needed to avoid marring the table. In countless ways which are continually presenting themselves, attention and interest will result in a saving that is invaluable.

Finally, when she is giving evening care before leaving the patient for the night, she notices that the night lamp is burnt out. She replaces it, to prevent a careless nurse from using a towel or paper to dim a light, for such a method is not only a fire hazard, but may result in the scorching of linen, a big item of wastefulness. She insures that all things needed for the patient's comfort during the night are in the department ready for use, and so prevents a waste of time for the night nurse. Spending hours searching for things is not only a lack of efficiency but is likewise annoying to patients. After turning out all unnecessary lights in diet kitchens, bathrooms, et cetera, the conscientious nurse reports off duty, not realizing, perhaps, the amount of money and of time which she has saved the hospital in a single day by her thoughtfulness and interest.

Let us briefly sketch in dollars and cents an estimated sum total to which economy practiced in this manner might amount. First, refinishing of the damaged sill resulting from an open window would probably cost 20 cents. Turning out the light which might have burned uselessly several hours would amount to 4 cents; and the turning out of other lights that are not needed at the time might save 4 cents. The prompt repair of a leaky radiator or faucet saves possibly 20 cents. Let us add 10 cents saved by observing the trays.

In these few items we find a total of 58 cents per day. Let us suppose that 20 nurses save this amount for a hospital each day. A little multiplication gives us the astounding amount of $4,234 for 365 days as the total of this combined effort at conservation for a year. Add to this the less frequent saving where care prevents the destruction of valuable articles such as the sterilizers, or where the timely repair of a radiator prevents a flooded room, and we realize what an asset to her hospital is the nurse who has the good judgment and the interest to be economical; what a real detriment is the one who is careless and wasteful.

It is evident as we consider these daily experiences that arise in the work of the nurse that economies of this nature are going to be practiced by the careful, thoughtful, dependable character. A nurse who is considerate and attentive in such matters toward the institution in which she is working will probably be equally reliable in the care of her patient. She has trained herself to observe and to be mindful of details. She will not forget the administering of medicines, the likes and dislikes of her patients. In short, she is quite sure to be the efficient woman who is always in demand.



Pitcher Picks P. H. A. Committees

Charles S. Pitcher, Philadelphia, president of the American Protestant Hospital Association, announces that the following will be the personnel of important committees of the association to work on indicated topics and to make a report at the 1934 convention:

LEGISLATION

Rev. Herman L. Fritchel, D. D., Milwaukee Hospital, Milwaukee, Wis.; J. B. Franklin, Grady Hospital, Atlanta, Ga.; John G. Martin, Hospital of St. Barnabas, Newark, N. J.; Joel C. Hiebert, M. D., General Hospital, Lewiston, Maine; Carroll H. Lewis, Christ Hospital, Cincinnati, O.; Chester C. Marshall, D. D., Methodist Hospital, Brooklyn, N. Y.; George Hays, Baptist Hospital, Louisville, Ky.

PUBLIC RELATIONS

Paul H. Fesler, Wesley Memorial Hospital, Chicago, Ill.; C. J. Cummings, Tacoma General Hospital, Washington; Clarence H. Baum, Danville, Ill.; George D. Sheats, Baptist Hospital, Memphis, Tenn.; T. J. McGinty, Davis Hospital, Pine Bluff, Ark.; Frank J. Walter, St. Luke's Hospital, Denver, Colo.; Rev. N. E. Davis, D. D., Sec'y, M. E. Board of Hospitals, Columbus, O.

FINANCE

J. H. Bauernfeind, Evangelical Hospital, Chicago, Ill.; B. A. Wilkes, M. D., North Hollywood, Calif.; Charles S. Woods, M. D., St. Luke's Hospital, Cleveland, O.; Louis J. Bristow, Baptist Hospital, New Orleans, La.; John G. Benson, Methodist Hospital, Indianapolis, Ind.; A. E. Paul, Englewood Hospital, Chicago, Ill.

MEMBERSHIP

J. Dewey Lutes, Ravenswood Hospital, Chicago, Ill.; Clinton F. Smith, Allen Memorial Hospital, Waterloo, Iowa; O. B. Maphis, Bethany Hospital, Chicago, Ill.; Albert G. Hahn, Deaconess Hospital, Evansville, Ind.; and chairmen of regional consulting committees.

NURSING

Mary B. Miller, R. N., Presbyterian Hospital, Pittsburgh, Pa.; Lake Johnson, R. N., Good Samaritan Hospital, Lexington, Ky.; Alice Taylor, R. N., All Saints Hospital, Ft. Worth, Texas; Lydia A. Miller, R. N., Asbury Hospital, Minneapolis, Minn.; Zillah MacLaughlin, R. N., Massachusetts Women's Hospital Boston, Mass.; Grace Hinckley, R. N., Methodist Hospital, Brooklyn, N. Y.; I. Craig-Anderson, R. N., St. Luke's Hospital, Davenport, Iowa.

MEMORIALS

Joseph G. Norby, Fairview Hospital, Minneapolis, Minn.; Philip Vollmer, Jr., Fairview Park Hospital, Cleveland, O.; E. E. King, Missouri Baptist Hospital, St. Louis, Mo.

TRAINING OF HOSPITAL EXECUTIVES

A. M. Calvin, executive secretary, Northwestern Baptist Hospital Association, St. Paul, Minn.; Robert E. Neff, University Hospitals, Iowa City, Iowa; E. I. Erickson, Augustana Hospital, Chicago, Ill.; J. A. Diekmann, Bethesda Hospital, Cincinnati, O.; A. O. Fonkalsrud, Ph. D., General Hospital, Mansfield, O.

HISTORIAN

Rev. Herman L. Fritschel, D. D.

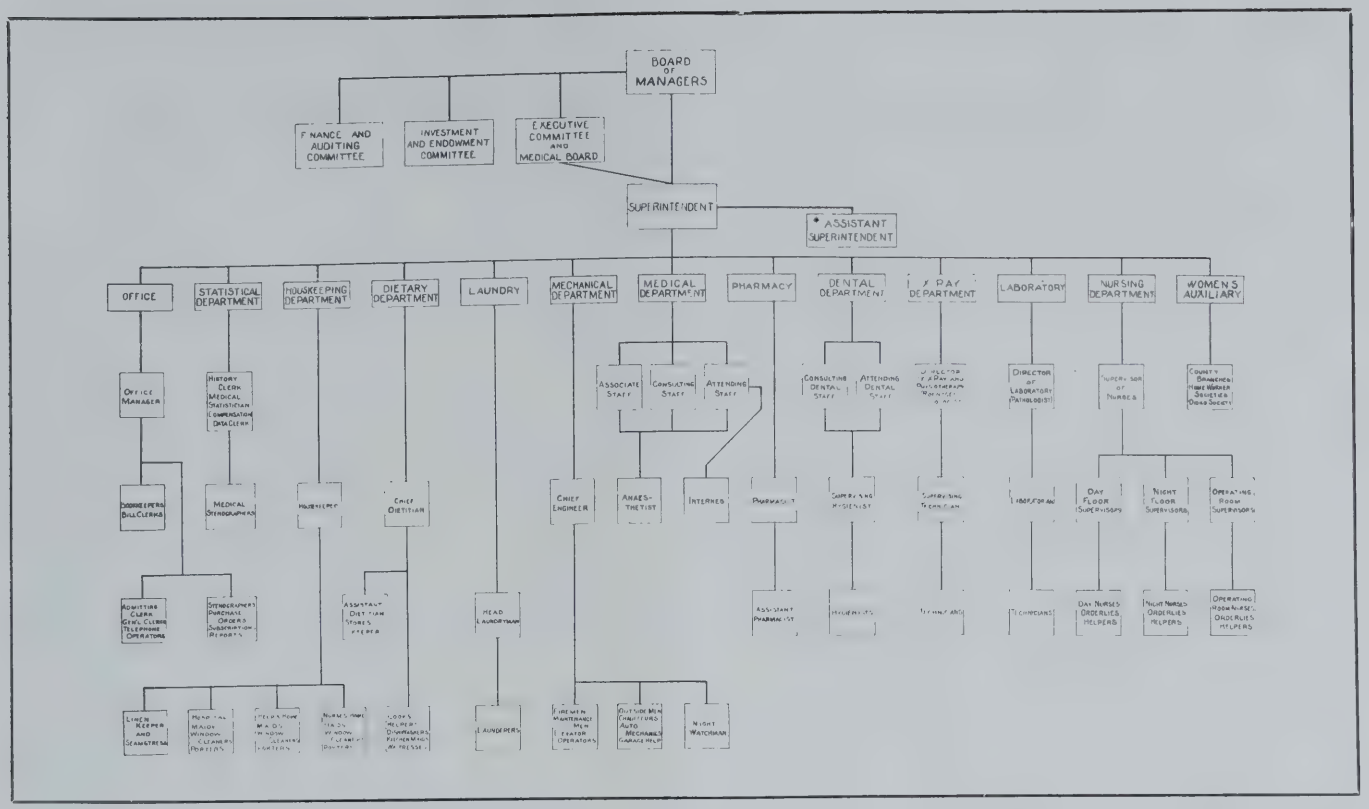


Chart of Organization, Nyack Hospital, Nyack, N. Y., Anne O'Donnell, Superintendent

Nyack Chart Clearly Outlines Superintendent's Post

THE accompanying chart of organization of Nyack Hospital, Nyack, N. Y., Anne O'Donnell, superintendent, is reproduced from the annual report of the institution as a suggestion to other hospitals which may not have drawn up such a graph.

The first comment that occurs on examining this chart is that it presents the position of the superintendent, with reference to relationships with board, staff, auxiliary and personnel, in a clear and definite way. A glance shows that all contact, upward and downward, through the institution must be through the superintendent or assistant superintendent. (The asterisk beside assistant superintendent refers to a note that was not reproduced above but which reads, "The assistant superintendent performs other regular duties and becomes acting superintendent during the absence or incapacity of the superintendent.")

Aside from a general guide showing the relationships in the Nyack Hospital, the chart gives specific information to readers regarding some of the functions of different departments. The housekeeping department, according to this chart, is definitely responsible for the linen keeper and seamstress, the hospital maids, window cleaners and porters in the hospital, nurses' home and help's home. The chief engineer is placed over the maintenance men, elevator operators, outside men, chauffeurs, garage and night watchman, and so on.

While such combinations may not be applicable to other institutions, the fact nevertheless remains that the chart clearly pictures the person responsible for the different activities and traces the relationship of this person to other department heads and to the superintendent.

HOSPITAL MANAGEMENT will be glad to receive copies of similar charts from other hospitals.

Cleveland Hospitals Have Finance Bureau

By Charles S. Woods, M.D.
Superintendent St. Luke's Hospital, Cleveland, O.

The Hospital Finance Corporation of Cleveland is a corporate entity not for profit under the laws of the State of Ohio, and has been in operation since June 1, 1933.

The purpose of the corporation is to serve as an agency for all members of the Cleveland Hospital Council in the following ways:

(a) to determine the credit ratings.
(b) to make financial arrangements with patients whom the hospital refers to it.
(c) to collect for hospital services which have been rendered to such patients.

The admitting officer gives the patient information about the cost of the service. If he requires deferred payments, he is given an application blank which he is asked to fill and present to the Hospital Finance Corporation. The corporation may take his note at 6 per cent, or may refuse to extend the credit, and will immediately notify the hospital of its action.

The successful financing of the corporation depends entirely upon the amount of business which the hospitals refer to it. Experience may show that 6 per cent is too low, or perchance too high. It is necessary for the hospitals to make a certain payment to the corporation in its first months of existence in order to maintain it until there is sufficient business to support it. It is hoped that the corporation may ultimately be able to advance the cash for hospital service at once.

The hospitals that have used the Hospital Finance Corporation most, are convinced of its great service.

15 Years Ago—THIS MONTH—10 Years Ago

From "Hospital Management," December 15, 1918

Hospital superintendents study problems resulting from the Armistice. Labor shortage, high wages and high prices of commodities received special consideration.

West Virginia Hospital Association announces new date for convention, which was postponed because of influenza epidemic.

"Who's Who" illustration is portrait of Asa S. Bacon and brief history of his numerous contributions to hospital field.

From "Hospital Management," December 15, 1923

Leading article suggests hospitals make a report to its community of year's activity similar to annual reports of business and other organizations.

Dr. MacEachern, president of the American Hospital Association, stresses membership increase as biggest need of A.H.A.

Many favorable comments developed from inspection of Bacon plan hospital in Chicago, German Evangelical Deaconess Hospital.

Constitution and by-laws of student nurses' association of Illinois Training School published.

Have Charitable Bequests Dropped 25-30% in 10 Years?

By CHARLES R. HOLDEN

AT the best, I fear that charities will have to face a decline of from 25 to 30 per cent in the amount of legacies received by them during the last ten years.

With regard to securing new provisions by will or by trust agreement, it is, of course, obvious that both actual reduction of the resources of those able to give, and apprehension as to future further reductions, make more effective, more persuasive and more direct appeals of the highest importance.

It is elementary in educational and charitable finance that without constant and urgent appeals for current gifts, there will be little prospect of gifts by will. It is not within my subject to discuss such practical methods of appeal for current gifts as those of some institutions which are seeking to have given to them, on a sort of rummage sale basis, securities as to which the holders are now doubtful and solicitous. I do believe any gift, even of only such prospective value, is a step well secured as a proof of interest and attention. And it is only by way of aroused interest and attention that a foundation can be laid for gifts by will.

The very fact, encountered so frequently as to make it appear universal, that donors express absolute inability to give now, may well be used, with proper tact and exercise of common sense, as the basis for suggesting that a gift be provided by will. And if it is objected that this cannot now be done without injustice to the family, the further suggestion is warranted that such provision be made subject to priority of due provision for the family.

Properly handled, every present refusal of current gifts may be made a practical leverage for future aid by will. This means, of course, that interest and attention have been secured by adequate presentation of actual and pressing opportunities and needs.

Finally, we have to meet at this time as never before the procrastination always encountered in having a will or codicil drawn and signed. I mean not only new wills, but also revision of old wills. Many, many people exclaim that their affairs are in such confusion and they suffer from such uncertainty that they do not know what they can plan for a will.

A will is a serious job for a well man. It should not be left as a labor to burden a sick man. To draw a will to safeguard and distribute an estate in sound condition is essential, is necessary to escape the absurdities, limitations and losses of obsolete administration statutes. To draw a will for such an estate is the only wise course. And it is simply folly if an estate is liable to be found unsettled, and with many unsettled problems, to fail to make adequate broad and sound provision to save and conserve it to the utmost. Obsolete laws, passed without either reference to or knowledge of present business and investment problems, will play inevitable havoc with an estate in sound order and condition. And with an estate in difficulty they are simply out of all question.

If a testator's house is not in order, he should not risk his death, leaving it in such shape, without due and ample provisions by will that will make it at least possible for his executor and trustee to save the utmost and restore the largest possible measure of order.

The appeal of the President for continued and active support by contributions to charities and educational institutions should be made a part of the background for presentation of appeals for current gifts and making provision by wills.

From an address by Charles R. Holden, attorney; vice-president, First National Bank, Chicago; A. L. A. trustee of endowment funds; author, "Estates Under Wills and Trust Agreements," before the Special Membership Committee to discuss promoting library endowment through bequests at the 1933 conference, American Library Association, Chicago.

COLUMBUS HOUSEKEEPERS

Officers of the Columbus Chapter of the National Executive Housekeepers Association are:

President, Mrs. Rhea J. Newquist, Neil House; vice-president, Mrs. Nan McCloud, White Cross Hospital; secretary-treasurer, Mrs. Ella Arnold, Fort Hayes Hotel.

Directors,, Mrs. Gertrude Glover, Miami Valley Hospital, Dayton; Mrs. Floy Merigold, Jefferson Hotel; Ellen Gillespie, Y. W. C. A.

Chairman of committees: House, Mrs. Beatrice Harlow, University Hospital; publicity, Mrs. Frances White, Hotel Roggee, Zanesville; Mina Bain, Hotel Harding, Marion; program, Mrs. Lelia Gastinger, Dayton.

THE HOSPITAL ROUND TABLE

Autopsies Increase

A striking picture of the increase in autopsies in hospitals is presented by figures compiled by the Council on Medical Education and Hospitals of the American Medical Association, which reports that in 1926, when the special effort for increasing autopsies was begun, only 103 hospitals had a percentage higher than 30 per cent. This year 305 hospitals have a record of more than 30 per cent autopsies. In 1926, 329 hospitals approved for intern training had less than 15 per cent autopsies, many of them a very small percentage or no autopsies at all. Now less than 60 of these approved hospitals fail to reach 15 per cent. It is estimated that something like 40,000 more autopsies are performed in the approved hospitals than before the Council began its campaign for autopsy performance in 1926.

Repeal and Accidents

The annual report of Dr. J. H. Stephenson, superintendent, Dallas, Tex., City-County Hospital System, calls attention to the fact that since beer was legalized in Texas the emergency division has had a marked increase in service. A majority of the additional accidents, according to the report, were caused by automobile drivers who had drunk to excess. Interesting features of the report included the statement that X-ray examinations had increased about 50 per cent and that a similar increase was shown in laboratory tests, and ambulance calls.

What It's For

Commenting on discussions of group hospitalization plans at the American Hospital Association convention in Milwaukee, the bulletin of the North Carolina Hospital Association makes some important points in the following:

"Most of these new plans appear to be based on the assumption that the contributor will want and will be able to pay for a private or semi-private room. In other countries, Great Britain, for example, the periodic payment plans entitle the contributor to the cheapest accommodations in the open wards. Hospitals as a rule do not lose money on the private and semi-private room patients. They lose money on the ward patients who have not accumulated enough money to pay an unanticipated hospital bill and their incomes are so small that it would be a hardship on their families to expect them to pay. It is this group that constitutes the real problem. If the low wage earner who now goes into the ward as a free patient became a contributor of 15 or 20 cents a week to a common fund for hospital service, that would guarantee the hospital $3 a day for every day he or a member of his family occupy a ward bed, most of the financial troubles of hospitals would disappear. That is the way Roanoke Rapids solved the problem many years ago."

Mite Boxes in Homes

A local committee, in connection with efforts to obtain a $3,000 quota from citizens of Suffolf, Va., for the proposed Tidewater Victory Memorial Hospital, recently placed mite boxes in homes of the community, into which members of a family were expected to insert coins from time to time. Later the committee members were to call for the boxes. This idea has been used by various institutions, but it may be adaptable to some hospital elsewhere as a means of obtaining small contributions from those who might otherwise not make any offering.

Making Friends in O. B.

An increasing number of hospitals are using attractive little birth announcement cards, which are available at low cost, to make friends with mothers and fathers and relatives of babies born in the institution. Among the institutions which adopted this idea through the recent availability of these cards at small cost is Martha Washington Hospital, Chicago, Edward Rowlands, superintendent. Mr. Rowlands a few weeks ago started the plan of supplying the mother of each newborn baby with six cards, to be filled in and addressed by the mother, the hospital furnishing the postage stamps. The cards chosen by Mr. Rowlands show a nurse and baby on the cover, with an oval background decorated with red. On the third page is the usual birth announcement, with the sex, name of baby, time of birth, weight, and the name of the parents. Below is the name of the hospital. An envelope to match completes the announcement.

Although in use only a short time, Mr. Rowlands has received a number of compliments and feels that the idea is well worth while.

Martha Washington Hospital also has a similar card, printed in red and blue, with a tiny birthday cake with one candle on the cover. Inside is a message of congratulation and good will from the hospital. These cards are to be sent to the babies on their birthdays, the dates being taken from the hospital records.

In some instances the birth announcement cards may be made to pay for themselves, for one hospital supplies two cards to the mother and furnishes additional cards at the rate of two for five cents.

Patient's Impression

A professional woman whose work necessitates her contacting many organizations and influential individuals recently told a friend, who was a hospital auxiliary member, her impressions of a two weeks' stay in a hospital: "There were two things that occurred constantly that annoyed and irritated me and, I feel, actually tended to retard my recovery. The first and most harmful, in my opinion, was the practice of awakening me each morning at 7 o'clock, regardless of whether I had tossed about, sleepless, until long after midnight. Of course, I realize that hospital routine must be considered, but I felt that sleep was doing me more good than anything else, and the awakening after only a few hours' sleep certainly seemed an act that tended to make my condition worse. The other thing to which I objected was the food, or rather the indifference shown to foods that I disliked and repeatedly said I didn't want. Apparently absolutely no effort was made to meet my wishes in this matter, although I was paying for an $8 a day room."

Reactions of a patient of this type are things that every hospital executive should study. While certain routine may not be changed to fit a special condition, yet efforts ought to be made to make patients of more than average intelligence to understand why requests may not be granted, and thus permit this patient to leave the hospital with a better feeling toward the institution.

Most Annoying Noises As Disclosed by a Unique "Noise Clinic"

(Parentheses denote number of repeated complaints)

Complaints from Department Heads, Supervisors

Dietary Department

Maids working in diet kitchen with doors open. (6)
Food carts. (2)

Engine Room

Ice wagon, rollers need oil.
Operator careless in opening doors. (5)
Radiators knock.
Noisy steam pipes.
Windows and screens rattle.
Door stops without rubber. (5)
Painters whistling and singing while working.

Doctors and Interns

Hard heels. (3)
Unnecessary talking in corridors.
Talking with nurses in chart rooms.

Housekeeping Department

Maids and janitors drop mop and broom handles, dust pans, etc. (7)
Careless handling of garbage can lids. (4)
Empty trucks are noisy.
Janitors moving furniture thru hall bump into doors. (4)
Careless handling of mops and buckets by early morning janitors.
Janitors coming on duty 5:00 A. M. talk too much. (2)
Excess talking in the basement halls by janitors and maids during lunch hour. (5)
Faucets running full force.
Flapping of window shades in new wing. (2)
Noise around time clock. (2)
Elevator doors. (3)
Furniture—screens, foot stools, chairs, beds, etc., need rubber tips. (9); dresser drawers stick, causing dresser to be dragged across floors. Rollers out of screens in patients' rooms. Desk drawers squeak.

Laundry

Laundry carts, loaded and empty, wheels are noisy. (4)

Nurses

Slamming of refrigerator doors 24 hours a day. (3)
Careless slamming of desk drawers and doors. (3)
Careless moving of nurses cots.
Empty linen baskets.
Charts in the old wing at night. (2)
Hard heels on house shoes. (5)
Hard heels on duty shoes—run over heels.
Handling of utensils in the medicine and utility rooms. (4)
Unnecessary talking in serving kitchens. (2)
Flapping of window shades in new wing.
Nurses and doctors congregating in chart rooms and halls. (4)
Nurses calling to one another in halls.
Disturbing noises from rooms above in new wings. (3)
Careless handling of wheel chairs.

Offices and Information Desk

Unnecessary loud talking. (3)
Noise from ditto machine. (2)
Noise at the cashier's windows. (2)
Visitors in lobby. (2)
Typewriter in registration office.
Commotion in the halls in front of offices.
Wheel chairs need attention.

Obstetrical Department

Rollers on bassinets.
Washing bottles in the milk laboratory.
Noisy cleaning trays.
Nursery drawers are left open.
Visitors. (3)
Excess talking in halls.

Pharmacy

Unnecessary loud talking. (2)
Drug cart bottles rattle. (3)

Surgery

Carts—wheels rattle. (3)
Blinds flap in E.N.T. surgeries.
Loud talking.
Traffic.
Pan boiler lids.
Calling orderlies. (Buzzer system needed.)
Careless handling of pans.

Telephone Office

Loud speakers. (7)

X-Ray

Carts.
Deep therapy machine.
Calling orderlies in corridors. (Buzzer system suggested.)

Outside Noises

Fire department trucks.
Dogs. (3)
Loud talking by residents in rear of hospital.
Automobile horns in front drive.
Capitol Avenue noises.
Police Department. (3)

Complaints from Members of Medical Staff

Tone down the amplifiers. (5)
Noisy rollers on furniture.
Loud talking of doctors in halls.
Visitors.
Employes using doctors telephone booths.
Noise from children's floor.
Stop pounding in building.

Complaints from the Patients

Noisy typewriters.
Racing of motors and honking of horns in back lot and front drive of hospital. (2)
Business office machine. (2)
Police Department. (3)
Fire Department. (4)
Noise of ice carts going thru halls.
Creaking doors and drawers in bedside tables. (3)
Delivery carts banging out and on elevators. (2)
Slamming of doors with stops. (4)
Washing dishes. (4)
Refrigerator doors.
Chairs need rubber tips. (3)
Elevator doors noisy.
Careless moving of furniture in rooms—while being cleaned and while occupied. (5)
Noise from rooms above. (6)
Doctors and visitors not observant of quiet rules. (2)
Early morning scrubbing halls.
Flapping of window shades.
Noise of keys in linen room doors.
Careless handling of utensils.
City hospital ambulances.
Police cars.

The above complaints resulted from the "noise clinic" of Methodist Hospital, Indianapolis, described on the opposite page. Perhaps there are some hospitals which can eliminate or minimize similar noises without the necessity of holding a "clinic," although most hospitals possibly will find a "noise clinic" a real advantage in curtailing noise.

Indianapolis Hospital's "Noise Clinic" Well Worth While

By JOHN G. BENSON
General Superintendent, Methodist Hospital, Indianapolis, Ind.

Here's something new in the field, a "noise clinic." The experience reported here and summarized in more detail as to findings on the opposite page suggests that a similar "clinic" would prove profitable to many other hospitals. One of the findings, says Dr. Benson, is that 70 per cent of the noise was found to be due to carelessness, in spite of the fact that every one connected with a hospital realizes that quiet is essential to the sick person.

"Hold a 'noise clinic,' providing you have courage to hear about your own noise faults," advises Dr. Benson. "It is mighty wholesome medicine for any hospital."

WITH apologies to Burns, the purpose of these words might be expressed thus, "Ah would the power the gift to gie us to 'hear' ourselves as ithers 'hear' us."

Since hospitals are treating sick persons it is necessary that an atmosphere of quiet and rest be maintained. Most patients are irritated by noises coming from a great many sources. Visitors laugh and congregate in the halls, the janitors are guilty of careless handling of the mop buckets, nurses and doctors talk too loudly. But hospital folks do not always realize how vigorously they create noises themselves that the poor patient must endure.

In order to ascertain just how many complaints and their nature, the patients had made in the Methodist Hospital, a noise campaign was inaugurated at a meeting of the Department Heads' Council. A committee was appointed to study the subject. In turn the department heads took the matter up with their own employes. A great many of the patients were interviewed and asked to specify the noises that bothered them. A thorough canvass was made of the doctors and altogether a most profitable clinic on noises was held with very practical results accruing to the benefit of the hospital, but most of all the patients.

As a result, a complete report was made and submitted by the committee. The results of this report are published in this article. Careful examination of the survey will show that about 70 per cent of the noises are due to carelessness alone. For instance, the maids working in the diet kitchens with the doors open, the painters whistling and singing while working, maids and janitors dropping mop and broom handles, etc.

The student nurses took a very active part in the noise campaign, drawing posters. Each class submitted three posters and a prize was given for the best one. These posters were judged by the members of the staff.

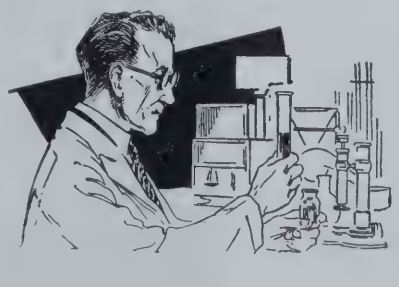
How many hospitals are guilty of the type of carelesness concerning noise as was found in this report? There is only one way to find out and that is to ask the patient. Hold a "noise clinic," providing you have courage to hear about your own noise faults. It is mighty wholesome medicine for any hospital.

Interest in this very important matter was stimulated by the noise campaign, the striking thing was that in a large percentage the hospital employes, including nurses and doctors, manufactured the noises about which they complained. Every one of our employes is striving to eliminate noise in order that the patient may recover more rapidly and leave the hospital satisfied that everything possible was done to speed his recovery. Still a more striking thing about this clinic was the cooperation of the patients and visitors in the campaign. This is shown in some of the extremely interesting answers that were submitted, including a cartoon on the "screaming furniture."

The "Noise Clinic" was such a success that we feel it should be made a permanent event, occurring periodically whenever the people of the hospital begin to forget. It helps us all to ever and anon take a critical view of ourselves.

MISS SHAW PRESIDENT

Ella M. Shaw, Helena Hospital, was elected president of the Arkansas Hospital Association at a special meeting recently, succeeding the late Monsignor John P. Fisher. The Rev. J. J. Healy, Little Rock, who was appointed director of Catholic hospitals of the diocese of Little Rock, succeeded Miss Shaw as vice-president of the association. Regina Kaplan, Leo N. Levi Hospital, Hot Springs, continues as secretary-treasurer. At the meeting a new organization was formed, the Council of the Arkansas Hospital Association, membership without dues. Lee C. Gammill, Baptist State Hospital, Little Rock, and Caroline T. Snyder, Trinity Hospital, Little Rock, are president and secretary, respectively, of this new organization which seeks to develop cooperation among all the hospitals of the state, to act as an executive board for the state association, and to represent and protect hospitals before the public.



HOSPITAL PERSONNEL

Departments and their personnel of Grace Hospital, New Haven, Conn., are thus listed in the annual report:

GENERAL ADMINISTRATION — Superintendent, secretary to the superintendent, office manager, assistant manager and keeper, bookkeeper, 2 cashiers, information clerk, 4 telephone operators, 4 admitting officers, 2 elevator attendants.

MEDICAL—44 physicians (consulting), 50 physicians (attending), 1 resident house officer, 8 interns.

NURSING—Superintendent of nurses, 2 assistants to the superintendent of nurses, instructor, secretary, 14 supervisors, including O. R., 40 general duty nurses, 15 ward helpers, 7 orderlies, 75 student nurses.

ANESTHESIA—3 attending anesthetists, resident anesthetist.

LABORATORY—Pathologist, secretary to pathologist, 4 technicians, attendant.

X-RAY—Roentgenologist, 2 technicians.

PHYSIOTHERAPY—Physiotherapist, secretary to physiotherapist, 3 technicians, attendant.

DRUG—Druggist, assistant druggist.

RECORD—Historian, assistant historian, medical stenographer.

DIETARY—Dietitian, 2 assistant dietitians, dining room supervisor, secretary, chef, 3 cooks, baker, 11 pantry maids, 15 kitchen men, 3 waitresses.

HOUSEKEEPING—Housekeeper, 2 seamstresses, 8 house maids, 8 laundry maids, 3 laundry men, 16 floor men.

STORES—Storekeeper.

MECHANICAL—Chief engineer, assistant engineer, night engineer, 2 firemen, plumber, carpenter, 2 painters, chauffeur, gardener, watchman, steamfitter, electrician.

Average patients, 197; beds, 247; bassinets, 40.

CLEVELAND HOUSEKEEPERS

Officers of the National Executive Housekeepers Association, Cleveland Chapter, are: President, Miss R. A. Lance, Mayflower Hotel, Akron; secretary, Mrs. Janet O'Toole, Park Lane Villa; treasurer, Mrs. Agnes Storz, Wade Park Manor; Mrs. A. B. Frey, Hotel Hollenden, chairman, national relations committee.

Why the American Physio-Therapy Association?

By MARGARET S. CAMPBELL

President, American Physio-therapy Association

THE American Physiotherapy Association, an immediate outgrowth of the world war work in physical therapy, was established in 1921 by the reconstruction aides who served during and following the war. Since then it has grown steadily until at present there are some 800 members scattered over the entire country. Many of these are members-at-large, but the majority are banded together in chapter groups in centers where sufficient members can get together. There are 17 chapters.

Quotations from the constitution will explain the salient points in the make-up of the organization and in the standards:

The purpose of this association shall be:

a. To form a nation-wide organ which will establish and maintain a professional and scientific standard for those engaged in physical therapy.

b. To promote the science of physical therapy by cooperating in the establishment of standardized schools of physical therapy and encouraging scientific research in the profession.

c. To cooperate with or under the direction of the medical profession and to provide a registry which will make available to the medical profession efficiently trained assistants in physical therapy.

d. To provide a bureau of information which will be available to members of the medical profession and the general public as well as to the members of the association.

e. To bind the local chapters together.

Active members shall have had at least one year's practice in physical therapy within two years of graduation from:

1. An approved school of physical therapy, by which is meant a school which gives not less than three years' training in physical therapy and which is on the approved list of the American Physiotherapy Association.

2. An approved course in physical therapy, by which is meant a course in physical therapy of not less than nine months, and which is on the approved list of the American Physiotherapy Association, following graduation from a school of nursing or a school of physical education which meets the requirements set by law in the individual states.

The standards of ethics for this association shall be as far as possible those of the American Medical Association. All members shall practice only under the prescription and direction of a licensed physician.

Members of the association are filling positions in various types of institutions: private, public and government hospitals; schools for handicapped children; industrial centers; private offices. In all cases, patients are referred by the doctors in charge of the cases, and the patients return to the doctors from time to time, as the doctors desire, for further information and orders. To practice independently is ground for expulsion from the association.

The national organization holds an annual convention. During the year, the various chapters hold their individual meetings for the transaction of local business and for educational purposes. The next annual convention will be held in Cleveland in June, 1934.

The official organ of the Association is "The Physiotherapy Review," published bi-monthly. In it may be found articles of help and interest to those practicing physical therapy, and even to nurses and physical educators—yes, and to physicians who are specialists in their branches. Subscription to the journal may be independent of membership in the association.

The American Physiotherapy Association wishes to offer to the readers of HOSPITAL MANAGEMENT any information they may require pertaining to the organization or membership of the association. It will be glad to be of service to them in providing material or suggestions for educational purposes. It has a classified list of its members and will be glad to aid hospitals in filling vacancies in their physical therapy departments.

Officers and executive committee of the American Physiotherapy Association:

President, Margaret S. Campbell, 950 East 59th Street, Chicago.

Vice-presidents, Marien Swezey, Gary Hospital, Gary, Ind.; Martha Hindman, 415 Hamm Building, St. Paul, Minn.

Treasurer, Mabel Holton, University Hospital, Ann Arbor, Mich.

Secretary, Mrs. Bess Searls, 1430 West 77th Street, Chicago.

Members-at-large, Florence Phenix, Department of Public Instruction, Madison, Wis.; Catherine Worthingham, 340 South 16th Street, San Jose, Calif.

Appointment Bureau, Emily Griffin, Monmouth Memorial Hospital, Long Branch, N. J.

Chairman, membership committee, Marien Swezey.

Chairman, committee on education, Mildred Elson, 942 North Jackson Street, Milwaukee, Wis.

Chairman, committee on publicity, Margaret Wallace, 728 Clark Street, Evanston, Ill.

Chairman, legislative committee, Mary E. Hibbler, 450 East 64th Street, New York, N. Y.

Advisory committee: John S. Coulter, M. D., Chicago; Ludvig Hektoen, M. D., Chicago; Dallas B. Phemister, M. D., University of Chicago Clinics, Chicago; Wallace H. Cole, M. D., Miller Clinic, St. Paul, Minn.; Frederick Gaenslen, M. D., Milwaukee.

Miss Campbell may be addressed care of the University of Chicago Clinics, 950 59th Street, Chicago.

SASKATCHEWAN MEETING

Economic problems occupied much of the program of the recent convention of the Saskatchewan Hospital Association in Saskatoon under the presidency of Leonard Shaw, superintendent, Saskatoon City Hospital. While not a large body, this is one of the most active associations in the Dominion. During the past year, the hospital and medical representatives have so joined forces with the municipalities and the provincial government that unusual progress has been effected in ironing out various difficulties. The program was well diversified and on two occasions the meeting was divided into groups to discuss urban problems, led by Dr. H. H. Mitchell of Regina; small hospital problems, under J. McQueen of Yorkton; union hospital problems, led by A. Esson of Rosetown, and nursing under Miss E. Amas. An interesting feature was the review of the work of a Junior Club at the Saskatoon City Hospital by Mrs. D. Rannard, a club formed a year ago on the suggestion of Dr. M. T. MacEachern. The Hon. Dr. F. D. Munroe, Minister of Health, and Dr. Harvey Agnew spoke at the annual banquet, the latter also conducting a general round table. Active on the program were Dr. H. E. Alexander, Saskatoon; S. R. Curtin, K. C., Regina; Miss C. E. Guillod, Maple Creek; Mrs. Helen Fraser, Hafford; N. C. Byers, Saskatoon; G. E. Patterson, the secretary; Dr. R. G. Ferguson and Dr. H. C. Boughton of the Anti-Tuberculosis League. Of particular interest was the A. C. S. film, "Good Hospital Care," and a remarkably entertaining amateur film of A Century of Progress by the energetic president, Mr. Shaw.

CHICAGO HOUSEKEEPERS

Among the members of the Chicago Chapter of the National Executive Housekeepers Association, Inc., are the following hospital housekeepers:

Mrs. Julia Beidel, Jackson Park Hospital; Mrs. Louise Fair, Cook County Nurses' Home; Mrs. Bella Leopold, Mount Sinai Hospital; Mrs. Anna McKenzie, Grant Hospital; Mrs. Marie Neher, Billings Hospital.

Mrs. McKenzie is a member of the board of directors. Officers of the chapter are:

President, Mrs. Lucy R. Kavanaugh, Hotel Belmont; first vice-president, Miss Anna J. O'Mahony, Hotel Southmoor; second vice-president, Mrs. Hannah Tanner, Mary Dawes Hotel; recording secretary, Mrs. Louis Olson, Sheridan Plaza; treasurer, Mrs. Mithilde Megelin, Lake Shore Athletic Club.

At the left is the original building of Milwaukee Hospital, which recently celebrated its seventieth birthday. Like many other of the older hospitals it had its beginning in a structure first built for a residence. This original building long since has gone.

At the right is a partial view of the present plant of the Milwaukee Hospital which also maintains a separate home for chronic patients as well as the usual facilities of a large up-to-date hospital. Many visitors to the 1933 A.H.A. convention had a chance to inspect this newest building. The Rev. H. L. Fritschel, D.D., who has been superintendent of the hospital for 31 years, is one of the few hospital administrators who also is president of his own board.

The first Protestant church hospital west of Pittsburgh was Milwaukee Hospital, sometimes also known as Passavant Hospital. November 5-7 it commemorated its 70th anniversary. On Sunday two services were held in the chapel; Monday was set aside for homecoming of the graduates of the school of nursing, 528 having been graduated since the school was established 30 years ago. On Tuesday the medical staff, the auxiliary and the interns' association were entertained at dinner.

Milwaukee Hospital was founded by Dr. Wm. Passavant in 1863 in a residence with 20 beds. Dr. Nicholas Senn was the first chief of staff. Especially within the last 25 years the work and the buildings have been expanded to large proportions. The hospital at present accommodates 250 patients. A home for incurables with 32 beds is a separate department. The school of nursing has an enrollment of 140. Dr. H. L. Fritschel has been general director of the hospital for 31 years.

NORTH CAROLINA OFFICERS

Newton Fisher, superintendent, James Walker Memorial Hospital, Wilmington, is president of the North Carolina Hospital association as the new year approaches. He was elected at the annual meeting in Charlotte.

The association voted to meet in Charlotte again next year on the third Wednesday in April.

Other officers of the association are: first vice-president, Dr. Moir S. Martin, Mt. Airy; second vice-president, Lottie M. Eure, Durham; third vice-president, T. J. Alford, Roanoke Rapids; secretary and treasurer, J. L. Melvin, Rocky Mount.

Board of directors: Dr. Brodie Nalle, Charlotte, Dr. J. T. Burrus, High Point; Dr. J. F. Highsmith, Fayetteville; Dr. Moir S. Martin; Virginia Marshbanks, Raleigh; Virginia O. McKay, Asheville; Hazel Williams, Charlotte; Mr. Fisher, Mr. Alford, Mr. Melvin and Miss Eure.

Dr. Highsmith, Miss Marshbanks and Mr. Alford are on the executive committee.

The association has four members to represent it on the state board of standardization for nurses' school: Dr. Ben Royal, Morehead City, Dr. Duval Jones, New Bern, Dr. Dave Tayloe, Washington, and Dr. Burrus.

WISCONSIN CONFERENCE

Officers in charge of the activities of the Wisconsin Conference of the Catholic Hospital association include Sister M. Felician, Milwaukee, president; Sister M. Beata, La Crosse, first vice-president; Sister M. Victoria, Ashland, second vice-president; Sister M. Marcelline, Madison, secretary-treasurer; board of directors: Sister St. Emily, Milwaukee, Sister M. Digna, Fond du Lac, and Sister M. De-Sales, Manitowoc.

Colorado Association Meeting Hailed as "Best Ever"

THE ninth annual meeting of the Colorado Hospital Association, November 15 and 16 at the Cosmopolitan Hotel, Denver, was one of the most successful ever held by the association. Nearly 200 persons attended the various sessions and the banquet.

The banquet was especially well attended, 125 members and guests being present. The program at the banquet was featured by the presidential address, "When Humanity Leaves the Hospital," by Frank J. Walter, St. Luke's Hospital, Denver, the retiring president. The association was also fortunate in obtaining from the American College of Surgeons the film, "Good Hospital Care," which was shown at the banquet.

Of particular interest on the administrative program was the talk on "Hospital Public Relations" by Dr Maurice H. Rees, dean and superintendent, University of Colorado School of Medicine and Hospitals. Dr. I. D. Bronfin, medical director, National Jewish Hospital, Denver, gave an excellent paper on "Protection of Employes in Tubercular Hospitals and Sanatoria," which is also worthy of special mention.

The dietetic section was featured by a paper by Dr. Thomas Donald Cunningham, Denver, "What Hospital Diets Should Contain," and by papers on "Cooperation Between Nurses and Dietitians," (1) "As Seen by the Nurse," by Mabel Humphrey, R. N., superintendent of nurses, St. Luke's Hospital, Denver, and (2) "As Seen by the Dietitian," by Rosella Hanfeld, dietitian, Mercy Hospital, Denver. These papers are published in this issue.

Another paper at this session was "Why the Adminitrative Dietitian?" by Ruby Kysar, dietitian, St. Luke's Hospital, Denver.

The nursing section was featured by papers by Dr. H. A. Green, medical superintendent, Boulder-Colorado Sanitarium, Boulder, on "What the Nursing Service Can Do to Aid the Hospital Administrator," and "Does Increased Teaching Bring About Better Bedside Care for the Patient," by Eula Lee Paullus, R. N., instructing supervisor of medical nursing, Colorado General Hospital.

Among other participants in the program were: Leslie F. Robbins, purchasing agent, University of Colorado; Eunice Robinson, executive secretary of City Charities, Denver; Robert B. Witham, director, Children's Hospital, Denver; Dr. Thomas Donald Cunningham, Denver; Lydia Beck, dietitian, Modern Woodmen Sanatorium, Woodmen; E. G. Fulton, Porter Sanitarium, Denver; Cora Kelly Kusner, dietitian, Colorado State Hospital, Pueblo; John E. Swanger, superintendent, Modern Woodmen Sanatorium, Woodmen; Elizabeth McKinley, social service director, Children's Hospital, Denver; Dr. Herbert A. Black, superintendent, Parkview Hospital, Pueblo; Sadie L. Heckert, R. N., president, Graduate Nurses' Club and the Central Registry, and Margaret Meyer, R. N., Denver.

The following officers were elected:

President-elect, Dr. John Andrew, Longmont Hospital Association, Longmont.

First vice-president, Dr. I. D. Bronfin.

Second vice-president, Sister Cyril, director, Seton School of Nursing, Glockner Hospital and Sanitarium, Colorado Springs.

Treasurer, Walter G. Christie, superintendent, Presbyterian Hospital, Denver (re-elected).

Trustees, Frank J. Walter, John E. Swanger, superintendent, Woodmen Sanatorium, Woodmen.

Guy M. Hanner, superintendent, Beth-El General Hospital, Colorado Springs, took office as president for the coming year. The board of trustees reappointed William S. McNary, University of Colorado Hospitals, executive secretary.—W. S. McN.

OKLAHOMA MEETING

Group hospitalization, public education, a program for crippled children, and legislation were the most interesting topics at the convention of the Oklahoma Hospital Association at Oklahoma City, Okla., on November 7-8.

Robert Jolly, superintendent, Memorial hospital, Houston, Tex., president-elect of the American Hospital Association, was guest speaker. Dr. A. J. Weedn was re-elected president and Dr. T. B. Hinson, Enid, and R. L. Loy, Jr., Oklahoma City, were re-elected vice-president and secretary.

Among those participating were Dr. L. J. Moorman, Dean of Oklahoma University School of Medicine; Dr. Fred S. Clinton; J. H. Rucks, superintendent Wesley Hospital, Oklahoma City; A. McBride, superintendent Reconstruction Hospital and McBride Clinic, Oklahoma City; Marjorie Ardrey, dietitian, University Hospital, Oklahoma City; Julia Marie Dries, superintendent of nurses, St. John's Hospital, Tulsa; Dr. F. E. Sadler, medical superintendent, Soldiers Tuberculosis Sanitarium, Sulphur; Dr. H. H. Wilson, medical superintendent, Western Oklahoma Hospital, Clinton; George Miller, superintendent, Morningside Hospital, Tulsa; Miss Henry, superintendent, Shawnee Municipal Hospital; Dr. A. S. Risser, Blackwell Hospital; Miss Biddle, Oklahoma State Board of Nursing Examiners; Mary Clark, Dr. T. M. Aderhold, Dr. O. J. Colwick, C. B. Hanna, Joe Hamilton, Dr. Earl McBride, J. A. Bivens, Jr., Dr. J. E. Harbison, Dr. Fred P. Von Keller, Dr. E. L. Emanuel, Dr. F. H. Hudson, Dr. Marvin E. Stout.

Dr. Peters to Retire; 44 Years at Rhode Island Hospital

DR. JOHN M. PETERS, for 44 years superintendent of Rhode Island Hospital, Providence, announced his resignation, effective January 1, on November 3, his 70th birthday, and the announcement was productive of numerous tributes.

In an editorial the "Providence Journal" summed up some of the kindliness and sympathy with which Dr. Peters discharged his duties in a tribute of which any person would be proud:

"He has been not merely the superintendent of the hospital, but literally the institution's host to the patients, showing a keen personal care for their welfare and comfort. Tens of thousands of persons in these 44 years have thus been helped and cheered by his quiet and comforting presence."

Dr. Peters has been an active member of the American Hospital Association since 1901, a few years after it was organized. He served as vice-president in 1904 and again in 1908 and was president in 1909. Dr. Peters has been regular in his attendance at national conventions and was present as usual at the 1933 sessions in Milwaukee.

It has been said that Dr. Peters is dean of hospital superintendents in the United States, in view of his record of 44 years in charge of Rhode Island Hospital. Incidentally, he became associated with the hospital as an intern a year and a half before he was appointed superintendent.

Dr. Peters was born in Syracuse, N. Y. He went to Phillips Exeter Academy, thence to Harvard Medical School, graduation in 1887, and in November of that year became an intern at Rhode Island Hospital.

Just before he was graduated from Harvard, he said in a recent newspaper interview, the medical profession was abandoning the use of a carbolic acid spray in the operating room, a spray that used to torture the throats of nurses and doctors because it was squirted indiscriminately over everything—the room, the instruments, and the surgeon, too. There was then coming into vogue the use of a weak solution of carbolic acid and bichloride as antiseptics.

At the Rhode Island Hospital then, he said, a couple of nurses, regularly on ward duty, would be told that Dr. So-and-So would operate at 10 o'clock the next morning. An hour or so before the operation the nurses would

JOHN M. PETERS, M. D.

go to the operating room and get ready, a very simple process in those days.

At the hospital now, there are 25 to 30 persons who give their whole time to the operating rooms and to the complexities of preparing for operations and sterilizing instruments.

"When I came here we had about 130 beds and now we've got 600," he continued. "It cost $50,000 a year for operating expenses then, and it cost $679,573 last year. In '88 there were about 902 patients for the year, and last year there were over 10,000."

In 1889 there were 40 doctors and interns connected with the hospital, and now there are 210 doctors and 24 interns. Incidentally, the beautiful intern building of recent construction is called the John M. Peters House.

"I just recalled," he said in the interview, "when I first came here the hospital was lighted with gas. We put electricity in the operating room about the second year. The nurses lived in one half of a tenement house, and we rented the other half to people from the outside. And our hospital telephone was on a five-party line.

"We've had a loyal organization here, one of the best. I've stayed here all these years, when it wasn't what I intended to do at all. But I've liked it, and I've never regretted it."

Dr. William O. Rice has been named acting superintendent of the Rhode Island Hospital to succeed Dr. Peters. Dr. Rice has been assistant superintendent of the institution since 1909, and for seven years has been president of the State Board of Nurses' Examiners, of which he also has been a member for 10 years. He also is a member of the board of managers of the District Nurses' Association. His hospital association memberships include those in the American Hospital Association and in the Rhode Island Hospital Association. Following his graduation from Brown University and Yale Medical School he began an internship in the Rhode Island Hospital in 1907.

Books for Those in T. B. Work

At a recent meeting under the auspices of the Chicago Tuberculosis Institute, Edna L. Foley, R. N., Chicago, suggested the following books as of special value to those engaged in tuberculosis work:

The Care of the Patient, Francis W. Peabody, M. D. Harvard University Press.

An Autobiography, Edward Livingston Trudeau, M. D. Doubleday, Page & Co.

Rules for Recovery from Tuberculosis. Lawrason Brown, M. D. Lea & Febiger.

Social Service and the Art of Healing, Richard Cabot, M. D. Dodd, Meade & Co.

Rest and Other Things, Allen K. Krause. Williams & Wilkins Co.

Environment and Resistance in Tuberculosis, Allen K. Krause. Williams & Wilkins Co.

The Tuberculosis Worker, Philip P. Jacobs, Ph. D. Williams & Wilkins Co.

Control of Tuberculosis in the United States, Philip P. Jacobs, Ph. D. National Tuberculosis Association.

Public Health Nursing, Mary S. Gardner, R. N. MacMillan Co.

The Care of Tuberculosis, J. A. Myers, Ph. D., M. D. W. B. Saunders Co.

The Magic Mountain (Vol. 1 and 2), Thomas Mann. Alfred A. Knopf.

Sanatorium, Donald Stewart. Harper & Bros.

We Take to Bed, Marshall McClintock. Jonathan Cape & Harrison Smith.

The Aetiology of Tuberculosis, Robert Koch, M. D. National Tuberculosis Association.

Improvised Equipment in the Home Care of the Sick, Lyla M. Olson, R. N. W. B. Saunders & Co.

Orthopedic Surgery for Nurses, Philip Lewin, M. D. W. B. Saunders & Co.

Heliotherapy, A. Rollier.

The Life of Herman M. Biggs, C. E. A. Winslow. Lea & Febiger.

Report of a Survey of the Schools of Chicago, 1932, Vol. 3.

Social Work in Hospitals, Ida M. Cannon. Russell Sage Foundation.

Pennsylvania Hospitals Successful In Relief Bond Issue

Quick Publicity Campaign, With Whole Hearted Cooperation of Trustees, Administrators and Friends of Hospitals, Save State-Aided Institutions from Financial Disaster

By M. H. EICHENLAUB

Superintendent, Western Pennsylvania Hospital, Pittsburgh; Chairman, Publicity Committee, Hospital Association of Pennsylvania

A CONSIDERABLE number of hospitals in Pennsylvania have felt for the past year or two that the public would like to be informed on hospital matters and as a result they have been financing a modest effort at publicity through the Hospital Association of Pennsylvania. Recently this informal organization had an opportunity to demonstrate its value when the voluntary hospitals of the state receiving state aid were threatened with a 25.3 per cent cut in state appropriations.

State revenues were lacking, an increase had been cast to the winds, and practically a third of what the hospitals had received before had been transferred to a $25,000,000 relief bond issue to be voted upon on November 7. Conditions industrially at the time had improved and few people believed any bond issue could be passed, and the hospitals were considerably disturbed to realize that they must support a political measure to secure an appropriation equal to that of the previous biennium. They had no choice, however. It was either work for the bond issue or fail in emergency free work. They decided to accept the terms imposed.

The association's publicity committee was asked to put aside all other projects and center attention on one thing—the Amendment known as No. 8, providing $25,000,000 for relief, of which only $2,231,365 was allocated to hospitals.

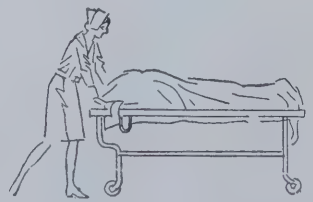
No funds for a campaign of this type were in hand, so the committee set about preparing material to be produced by the hospitals in their own communities. Within two days after the meeting was held authorizing this abrupt change in direction, material was pouring into the mails to not only 163 state-aided hospitals, but asking the help in their own interest of the 42 non-state-aided institutions which would suffer from further curtailment of service by their neighbors.

Time, however, was short. Swift action was needed. Against its better judgment, the committee decided to *produce* posters, leaflets and cards, as well as letters, and place them complete in the hands of the hospitals, instead of waiting for requests. A total of 30,000 posters, 230,000 cards and 225,000 leaflets were so distributed in a short time; and they were well used by all the hospitals.

The key to the entire endeavor was to urge each board and each hospital to interest its own friends and community in the issue. Meetings were arranged, radio was used, letters were sent to many organizations, and even 200 firms supplying hospitals in Pennsylvania were asked to give their help. The churches were interested; in fact, November 5 was designated as "Hospital Sunday." And the friends of relief work and of the universities which also had been included in the bond issue to the extent of twenty-two and a half millions of dollars were contacted. Women's clubs, the National Economy League, the medical profession, and many other groups threw their strength back of the appeal.

The striking thing is that while the bond issue was for $25,000,000 and hospitals were to share only to the extent of $2,231,365, everyone recognized the need of the indigent sick as pre-eminent and used it persistently.

While all these activities were under way, the Publicity Committee laid down a barrage of newspaper articles in dailies, weeklies, and through the leading wire services serving the state, with the result that the issue was greatly clarified.



Finally, the election. And here the hospitals demonstrated how deeply in earnest they were. They manned the polls—with board members, superintendents, nurses, social workers and other personnel—and stayed at these polling places throughout the day. Not just in one county, but in scores of counties. This may have seemed unprofessional to some, but they did it pleasantly, and there was not a breath of criticism. On the other hand, voters were made aware of the necessity for passage of the Amendment. It must have been effective, for the final vote was four to one in its favor—and this despite the misgivings of political leaders all over the state a few weeks before.

The tabulated vote showed:

Yes, 1,120,000.

No, 325,000.

Amendment No. 8 not only drew a larger vote than all other amendments on the ballot, but established a record in Pennsylvania, where normally only eight per cent of the voters have ever voted on a constitutional amendment or bond issue.

The cost to the hospitals was negligible, covering only postage, mimeographing, printing, telephone, etc. It simply required taking over temporarily the services of the publicity director and his assistant. Faith in the value of publicity for educational purposes has been justified. A great many hospital men and women are of this opinion. The indispensability of united action has been demonstrated and the committee is increasingly hopeful of proving that value to the voluntary hospitals for the sake not only of the institutions but of the indigent sick and unemployed who depend upon them for medical relief.

100 Questions and Answers

Here are the questions offered by the American College of Surgeons as timely and of greatest current interest, and the answers by the man who has conducted round tables at which these questions were discussed.

By ROBERT JOLLY
Superintendent, Memorial Hospital, Houston, Tex.

Be sure to read these questions and answers which began in the November, 1933, issue. The questions are those selected by Dr. MacEachern of the American College of Surgeons as most interesting and practical of the many received during the past year in connection with the hospital standardization movement. Mr. Jolly has been selected many times by the A.C.S. to conduct round tables at its sectional and national hospital conferences, and he answers these questions from this most advantageous background. The remainder of the questions will be answered in subsequent issues until the 100 have appeared.

PERSONNEL

15. *Has any one worked out a uniform or standardized nomenclature for hospital personnel?*

15. Not that I am aware of.

ADMISSION OF PATIENTS

16. *What are the essentials for a good admitting department?*

16. (1) Well located office.

(2) Competent, neat, courteous clerk, preferably a nurse.

(3) A machine for making sufficient copies of admission information to be distributed to different departments.

17. *What is the best method of handling reservations for accommodations?*

17. Book such as hotels use. Credit information from retail credit association, doctor and other sources should be obtained and recorded in this book before the arrival of the patient so there need be no uncertainty when the question of finances is handled.

DEATHS

18. *What routine should be followed in case of death?*

18. Call (1) house physician; (2) nearest relative; (3) attending physician; (4) mortician; (5) main office.

19. *What is the legal procedure for registration and disposal of the body in case of (a) stillborn infants; (b) recent or remote injury; (c) illegal operation?*

19. (a) After five months a baby born dead is a stillborn. Birth certificate and death certificate should be filled in and signed by doctor and body released to parents or mortician who must bury it.

(b) Homicide branch of police department must be notified and then proceed as in 18.

(c) Physician in charge should have consultation, get statement from patient and a relative, if possible, sign a statement that he himself had nothing to do with the condition of the patient upon admission to the hospital and file all statements and consultant's conclusion with the patient's record. Then proceed as in ordinary case.

TRANSFERS

20. *What is the best procedure in making transfers of patients from one ward to another in the hospital?*

20. Floor supervisor should get permission from physician and the patient or nearest relative then call nurse and porters and move the bed if possible. If bed can not be moved then, of course, stretcher may be used.

21. *In making transfers what should be the responsibilities of the (a) attending physician; (b) business office; (c) floor supervisor; (d) admitting officer?*

21. (a) Assure himself and the floor supervisor that the transfer in no way will injure patient or retard recovery.

(b) To see that records in every department are corrected and financial requirements are met.

(c) To make all arrangements for and to supervise the transfer.

(d) To work in conjunction with the business office.

What They're Thinking About

While we are pushing forward to increase employment and return the nation to better conditions we should not forget the sick, wounded and crippled in the economic struggle. Hospital doors must not close against those who are doubly distressed—the sick and the poor.—President Roosevelt.

More contributors to hospitals must be found, although they may not be able to give as substantially as some friends of hospitals have done in the past. The group payment plan must be relied on to help the white collar worker help himself. It is imperative that assistance from tax funds be provided in greater volume in the present emergency.—Henry J. Fisher, president, United Hospital Fund, New York.

Good hospital advertising comes from within, as largely as from without. Patients leaving the hospital are messengers of good will—hence we believe no effort should be spared to make the patient's hospital days such that he may truly say: "No better service should be expected, and the hospital is cheery and a feeling of comradeship prevails throughout."—Margaret Phynas, president, United Hospital Aids Association of Ontario, Burlington, Ont.

"Every Large Hospital Should Have Instalment Payment Plan"

By W. L. BABCOCK, M. D.
Director, Grace Hospital, Detroit, Mich.

AN instalment payment plan, based on an agreement between the hospital and the responsible member of the family, should be a part of the business administration of each large hospital. The plan should include:

Complete social statement of the family.

Signed statement from reliable head of the family as to amount and date of instalment payments.

Hospital tickler or blank to be sent 48 to 72 hours in advance of payment.

Check list of instalment accounts, arranged by days, thereby producing a daily work sheet so that the account number registered under each day be billed; and on the day due, if not paid, be investigated and checked by a representative of the auditor's office. This checking is done by telephone, mail, or through the family physician or place of employment.

The success of this plan depends wholly on the check-up of accounts not paid on the day due. This follow-up is imperative and should be prompt. Since the bank holiday, this plan has been followed in close detail and with moderate success. The percentage of total collected, as shown, increased each month coincident with the increase of employment.

The deferred payment plan, presented to the American Hospital Association in Toronto in 1931 and used in Detroit for several years, is an ideal plan if proper co-operation can be maintained between the bank, the hospital, and physicians. This plan had been in use several years up to the time of the bank holiday and would have been continued if the bank carrying the plan had re-opened.

This plan, which is applicable to private patients and patients of moderate means who own property, have regular positions, or have credit standing with the leading merchants, is as follows:

Patients are socially investigated and approved on the basis of past performance and reliability.

All qualifications stated above are not required in a given instance.

The bank loans the full amount of the bill on the basis of 6 or 7 per cent interest, without bonus—the interest charge for the term of the note being added to the note or deducted from the first payment.

The hospital credit investigator is made an agent of the bank and all notes and transactions carried out at the hospital. A social record blank is used and data thereon is obtained by the credit investigator, as in the case of ordinary social service investigations.

Where possible, we insist that the patient or patient's family exhibit a spirit of co-operation by paying part of the bill, or at least make an initial cash payment. In a few cases, notes have been taken for the entire amount of the bill.

The hospital treasurer endorses the notes after they receive his approval. Endorsements from relatives or friends of the family are also obtained where possible.

Physicians and surgeons on the staff are included in this agreement and avail themselves of the service whenever necessary. They, of course, endorse the patient's note, instead of the hospital treasurer. They receive their check at the hospital the following day during their regular visit. The hospital credit investigator handles this work for the doctor without charge, as it involves little or no extra work in connection with the hospital note. Practically all of our physicians have availed themselves of this service and are enthusiastic about it.

Notes are usually drawn for nine months at 6%; occasionally ten months; payments to be made monthly or semi-monthly, depending on the size of the note or payday of the signer; payments range from $2.50 to $30 each, depending on the size of the note. In the case of married couples, the husband and wife are both requested to sign. Greater discrimination is used in offering this service to unmarried people. Notes are sometimes signed in blank on admission of patient to hospital with the understanding that the face of the note will be the sum represented by balance due on account. The notes are drawn for balance due on account, filled in, forwarded to the bank during banking hours and the checks returned by the bank the following day. In other words, the hospital has the full amount of the account in cash within 24 hours.

Patients and relatives who have had this accommodation are also highly pleased; they feel that they meet their obligation in full on leaving the hospital. In other words, they sense that the hospital is extending them credit in a business-like manner, in many cases on "honor." The psychology is apparent. It is also believed that they are more likely to meet their payments at the bank than if it was an open account at the hospital, which they would classify with other unpaid bills.

From round table discussion, 1933 A. H. A. convention.

BRITISH COLUMBIA MEETING

The 1933 British Columbia Hospital Association meeting was most successful and reflected much credit on the president, J. M. Coady, and the secretary, J. H. McVety, both of Vancouver. The attendance from distant points is always good, largely owing to the system of pooling of traveling expenses. A recent reduction in the government grant to hospitals is causing the hospitals much hardship, it was agreed. This province has been interested for some time in various forms of health insurance and there seemed general agreement that some form of insurance, either of a voluntary group nature or under a general compulsory system, was advisable. Dr. M. T. MacEachern, Chicago and Dr. Harvey Agnew, Toronto, were guest speakers.

Active on the program were Dr. A. K. Haywood, superintendent, Vancouver General Hospital; Dr. H. E. Young, Provincial Officer of Health; Helen Randall; Dr. D. A. Lapp, Tranquille Sanatorium; Sister John Gabriel, Seattle, and Charles McHardie, Nelson.

Resolutions adopted included demands for restoring provincial grants to the former level, an increase in municipal grants and a more satisfactory arrangement with the Workmen's Compensation Board. It was agreed that legislation be sought making it obligatory for insurance companies to pay hospital accounts directly and making it legal for the insurance companies to deduct the amount paid the hospital from the amount due the injured party under the policy. It was agreed that the period of limitation of liability for negligence on the part of the hospitals be shortened to one year.

JOBLESS IN HOSPITALS

An inquiry involving 3,000 patients out of 212,882 ward patients in the United Hospital Fund hospitals, greater New York, and 290,757 patients of all classifications recently showed 52 occupations represented among the heads of families of ward patients and that not only laborers, artisans and industrial workers, but many business and professional people, are in need and unable to pay for hospital care.

The outstanding fact disclosed was that the largest number among the 3,000 ward patients needed free or partly free care because they are out of employment. The group of 327 patients who are not employed represented 11 per cent of the whole. If the same percentage of unemployed patients exists among all the ward patients in the 56 hospitals of the Fund, not less than 23,000 people require free or partly free care in the Fund hospitals because they are out of work.

WHO'S WHO IN HOSPITALS

THE re-election of John E. Lander as president of the Kansas Hospital Association is considered by members of the Association and those who know Mr. Lander well, to be only a tribute to his untiring interest and activity on behalf of hospitals. In this connection it must be noted that members of the Association insisted that besides retaining the presidency Mr. Lander also retains the chairmanship of the legislative committee.

Mr. Lander's particular interest in hospital administration is good business organization and efficient collection systems. He recently wrote a series of articles on collections for HOSPITAL MANAGEMENT and his further interest in this subject is shown by the fact that he has served for a number of years as director of the Wichita Retail Credit Association. It was due in great measure to Mr. Lander's activity, according to his friends, that the maximum payment for hospital and medical care under the state workmen's compensation law, was raised from $200 to $500.

Mr. Lander is a graduate of the law school of the University of Michigan, and later was a pastor in the Methodist Church. During his service he became interested in hospitals and has been financial secretary for Wesley Hospital for eight years.

F. W. Brouitt has been appointed superintendent of the Warren, Pa., General Hospital. Mr. Brouitt was former assistant director of the Hamot, Pa., Hospital and leaves this hospital after 20 years of service.

Margaret Brooks, operating room supervisor of the Moline, Ill., City Hospital, has been appointed superintendent of that institution, and E. W. Wegge has been appointed business manager.

Edward Groner, for the past two years superintendent of Baptist Hospital, Alexandria, La., has resigned to accept a position with the Southern Baptist Hospital, New Orleans. Dr. H. O. Barker has been selected to succeed Mr. Groner as superintendent of the Alexandria Baptist Hospital.

Sister M. Fidelis has been appointed superior at the Holy Family Hospital, La Porte, Ind., succeeding Sister Helen, who was first superior of the institution and in charge since 1900.

Gladys Krase has been appointed superintendent of nurses at the Cottage Hospital, Galesburg, Ill., succeeding Marjorie Schawley, who resigned.

Sister Martha Proehl has resigned as superintendent of St. Luke's Hospital, Saginaw, Mich.

Arlene Kitching resigned her position as laboratory and X-ray technician at Staats Hospital, Charleston,

JOHN E. LANDER
Financial Secretary, Wesley Hospital, Wichita, Kan.

W. Va., to take a similar position in the Presbyterian Hospital, Ganado, Ariz.

Sister Mary Denise, formerly superintendent of St. Elizabeth's Hospital, Elizabeth, has been appointed superintendent of St. Vincent's Hospital, Montclair, N. J.

Josephine Valentine, formerly with the Wisconsin Bureau of Nursing Education, has been named superintendent of nurses at Ohio Valley General Hospital school of nursing, Wheeling, W. Va. Virginia Kasley continues as assistant superintendent of nurses, to which post she recently was appointed. J. Stanley Turk is superintendent of the hospital.

Theresa M. Gust, superintendent, City Hospital, South Haven, Mich., since March, 1931, resigned December 15 for a short vacation before becoming superintendent of the Three Rivers Hospital, Three Rivers, Mich. Barbara Watson, who has been associated with the South Haven Hospital since 1929, has been appointed acting superintendent. Miss Gust succeeds Mrs. Effie Chapin Van Selous, R. N., a graduate of Hackley Hospital, Muskegon, who has been superintendent of the Three Rivers Hospital for four years. Mrs. Jessie Cooper Congdon, R. N., who has been Mrs. Van Selous' assistant, has been named acting superintendent until Miss Gust takes up her duties.

E. G. Fulton, manager, Porter Sanitarium and Hospital, Denver, recently also was assigned the responsibility of the business management of the Boulder-Colorado Sanitarium, Boulder. This means a great deal of extra work for Mr. Fulton, but he reports that the recent acquisition of the latest model Franklin automobile materially cuts down the time necessary to go to and from the Boulder institution, which is 40 miles from Denver.

P. J. McMillin, for a number of years superintendent of City Hospital, Cleveland, O., has been named superintendent of Baltimore City Hospitals, Baltimore, Md. Mr. McMillin has been active in the Ohio Hospital Association and a regular visitor at national meetings. He was in charge of the Cleveland institution since 1922.

Nellie Mumford, formerly technician in the Stouder Memorial Hospital, Troy, O., is the new superintendent of the Wallace Memorial Hospital, Lebanon, Mo.

Esther Wolfe, for the last seven years superintendent of the Ashton Memorial Hospital, Pipestone, Minn., and her assistant, Miss Gena Fiskness, resigned recently.

MR. DODGE IS DEAD

Ira J. Dodge, superintendent of Huron Road Hospital, Cleveland, O., since May, 1932, died at Homeopathic Hospital, Washington, of pneumonia which he contracted while negotiating in Washington for a $380,000 federal loan to complete the hospital's new buildings.

Mr. Dodge died as government officials said the loan would be granted as soon as legal formalities had been complied with, dispatches said.

Mr. Dodge, who was 49, was a world war veteran. He was assistant superintendent of Mount Sinai Hospital for several years and left there to be superintendent of the Marietta, O., Memorial Hospital. He came to Huron Road Hospital from Marietta.

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Making Better Friends of Patients and Visitors

HOSPITAL MANAGEMENT believes that many hospitals will join in the idea of making "1934 a year of education for patient and visitor," and follow the simple, inexpensive, but wholly effective program which is outlined in the leading article in this issue.

The advantages of this plan are that it is easy to operate and that it is inexpensive; that is, promises results that will directly benefit the individual hospital.

About the only originality about the idea is that it suggests a combination of three means of informing the patient and visitor: the leaflet, the poster, and the bulletin. The combination, it is believed, will add to the effectiveness of the program and will tend to strengthen and increase the results from each of the three items. However, any one of the three plans will be proportionately effective if carried out on a definite schedule.

One of the most important features of the proposed year of education is that the program should be undertaken with the firm resolve to carry on for a year. To distribute the material for a few weeks and then to quit will be almost a waste of money and effort, as the article points out, but if the program is definitely scheduled as a year's operation and the leaflets and bulletins distributed regularly, and the posters displayed and changed from time to time, then real results are to be expected.

A feature of the year of education which should appeal to everyone is that it is simple and may be carried on entirely within the hospital. There are many effective and admirable forms of public education which, however, require some special talent or opportunity, such as an address before a club, or over the air. The year of education, however, may be carried on within the walls of the hospital, without fuss or interruption of service, and it is certain that with all of its operating simplicity and unobtrusiveness it will make real friends for the hospital and many of them.

There are many activities of an educational nature which depend to a considerable degree for their effectiveness upon the cooperation of a number of other hospitals, or of the public or of various organizations. Sometimes it is impossible to get these various factors into complete agreement. Here again, the year of education has an advantage, for even if some of the hospitals in a community do not join, those institutions which do carry out the program will reap the benefits nevertheless.

Enroll your hospital with "the year of education" movement which promises so much in the way of real benefits to each institution. Show the field and especially those leaders who for so long have been stressing the need of a continuous educational program that you not only realize this need, but that you are trying to meet it in an effective way.

Will Your Hospital Publish An Annual Report?

Every community hospital ought to publish an annual report, and those institutions which will make such a report on a calendar year basis ought now to be giving some attention to the matter. It is good business to publish the report shortly after the end of the period for which the report is to be made, and not to delay. Timeliness in annual reports is stressed as an important advantage by some authorities in publicity and public education.

These remarks will deal with the annual report as a report to the community of service rendered, expenses incurred, etc., and not as a lengthy document going into considerable detail in various professional, technical and statistical subjects. A fairly concise report, with not too many figures (and these clearly explained or interpreted) is without doubt the most satisfactory report that most community hospitals can issue, for these hospitals should consider the report primarily as a means of informing the public of work done for the community and of explaining to the public in a general way some of the leading problems of the hospital and its plans for further serving the community.

If the institution desires to prepare a detailed account of medical and other professional services rendered, this ought to be done by the chief of staff, or under his supervision, and it ordinarily ought not to be distributed to

the general public. Likewise, detailed statistics of an administrative or other nature, which are intelligible only to those quite familiar with hospital administration, ought not to be included in the report to the community.

Pictures, charts and other illustrations ought to be used, even in a report of comparatively few pages, because these help the reader to visualize the amount of service, difficulties, needs, etc., much more quickly and clearly than long columns of figures or of printed explanation.

An annual report, written in interesting fashion, concise, with two or three illustrations, is worth a great deal to any hospital. And don't forget that human interest story, preferably one involving a child, a mother or a wage-earning father—and with a happy ending.

Actually it is much easier and much more fun to prepare the right kind of an annual report, the kind that is effective with the public, than it is to present long, unbroken, and, to the public, meaningless tables of figures and statistics.

So, even if your hospital has never printed a report before, plan to do so for the current fiscal year, whether it ends December 31 or at another time. A report for the community will win friends for you and may be the means of bringing to the hospital some bequest or gift that will make badly needed improvements possible, a bequest or gift that possibly might never be obtained otherwise.

Publicity Pays Pennsylvania Hospitals $2,000,000

The value of publicity or public education was graphically demonstrated in the victory of state-aided hospitals in the recent relief bond issue vote in Pennsylvania, for this bond issue was victorious despite predictions of well versed politicians that it would fail. And without question it would have failed had not the state hospital association so vigorously and so widely carried on its public education program.

The value of a program of public education thus is strikingly shown in the four-to-one margin by which the funds which stood between the continuation of the state aided hospitals and disaster to these institutions were voted. But a program of public education, whether carried on by an individual hospital or by a local or state or sectional group is just as effective, although its results may not be so spectacular or so definite.

The experience of the hospitals of Pennsylvania ought to "sell" every state association and every hospital on the value of public education and ought to encourage the associations and the individual institutions to begin such a program without further delay. Incidentally, a practical way for many hospitals to start on an individual basis is to join the year of education of patients and visitors suggested by HOSPITAL MANAGEMENT in the leading article in this issue.

These remarks on the success of the Pennsylvania hospitals' campaign to have the relief bond issue passed may not be closed without a word of congratulation to the officers of the association and to all of the members who participated, with a special commendation to those in immediate charge of the educational program.

Pennsylvania hospitals not only have saved themselves, as some hospital authorities of the state assert, in their successful effort, but they have given the whole field a practical lesson in the dollars and cents value of an educational program. And there's no telling when other states or communities may need just such an effort to save their hospitals.

Why Not a "Noise Clinic" In Your Hospital?

Methodist Hospital, Indianapolis, had a great deal of success with its recent "noise clinic" described in this issue, and Dr. Benson suggests that a similar clinic would be beneficial to many other hospitals. To show that he practices what he preaches, he adds that a "noise clinic" will be held from time to time in the future at Methodist Hospital.

Hospital administrators are quick to recognize the wear and tear on nerves and vitality of a patient that noise causes, but few hospitals perhaps have gone to the extent to hold a "clinic" and to have personnel, staff and patients all join in a study to find out what are the most common and most annoying noises and what causes them.

Such a study was made at Methodist Hospital, and as mentioned in the last issue, the participants had some fun and amusement even while they were attacking a very serious hospital problem.

It goes without saying that Methodist Hospital will not be so noisy after this clinic as it was before, until human nature begins to get in its work again and carelessness results in a gradual loosening of anti-noise restraint. But then, says Dr. Benson, there will be another "noise clinic."

Seriously, such a study of the causes of noise as was made by Methodist Hospital undoubtedly may be duplicated with a great deal of benefit by many other hospitals. A "noise clinic" might be jotted down as one of the activities that many superintendents will want to carry out early in the new year.

HOSPITAL MANAGEMENT will be glad to hear from other "noise clinics."

Support A. H. A. Representative at Washington

Since the editorial in the last issue urging the hospitals of the United States to support the plan of the American Hospital Association to maintain a representative of the field on a full time basis, the A. H. A. has announced the selection of its representative, who already has gone to Washington to look after the interest of the hospitals. The selection has caused most favorable comment from those who know the man. He is George A. Collins, for many years interested in hospital work in Denver as manager of the city hospital, and a person with a real interest in the hospital field and in hospital administration as was proved by his regular attendance at conventions and his active participation in programs.

Mr. Collins brings to Washington a full appreciation of the problems of hospital administration and a long experience in politics, a combination of qualifications which are essential in order that the field may have effective representation.

A point that cannot be emphasized too greatly is that Mr. Collins will labor on behalf of every ethical hospital in the country, whether that hospital is a member of the American Hospital Association or not. Every hospital, therefore, should do all it can to help to maintain the field's representative at the nation's capital by making a contribution of at least five dollars to help defray the expense of this representation which is being borne by the A. H. A. It goes without saying that this sum would be a very small part of the direct expense on practically every hospital that might be incurred through failure of Congress or some national official to give proper consideration to the problems of hospitals in the enactment or enforcement of tax or other laws.

When Hospitals Used Fish Kettle Sterilizers Sea Sponges and Cotton Gloves in Surgery

By M. I. ROSENTHAL, M. D.
Chief Surgeon, St. Joseph's Hospital, Fort Wayne, Ind.

IT was in the early '90's that I brought the first instrument sterilizer to the hospital—a long oval fish kettle with a false bottom, the handles so bent that the false bottom could be elevated and held in place. This served also as an instrument tray. It at least was reliably sterile.

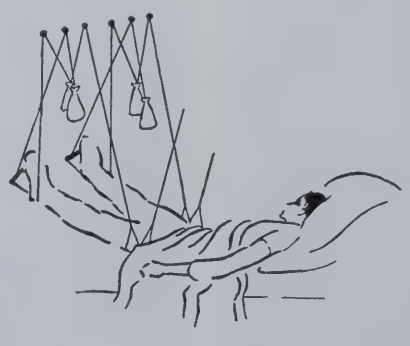
At this time most surgical instruments had wooden handles with deep bacteria-retaining grooves to secure a better handhold. The Sisters began to boil the instruments and this was disastrous to the handsome wooden handles. It is true, antiseptic surgery was in vogue. Some surgeons immersed their instruments in carbolated solution. In fact, actual animal sea sponges were in use. Nice broad, silky flat ones were abdominal sponges. Round ones and less expensive were used to mop out wounds with antiseptic solutions. The carefully prepared gauze pads which we now use replaced these sponges, but they retained the name. We still call them sponges. Laudable pus was the order of the day.

The antiseptic method was just being abandoned for the aseptic method in surgery. We had much to contend with. Some of the doctors still doubted the germ theory. They might be the result, not the cause of infection; foresooth, did not wounds suppurate worse than ever when washed with very strong antiseptic solutions? You can very readily imagine what such ideas did to technique and discipline in the operating room. Dressings and utensils were none too reliably sterile since the apparatus generally in use was more or less crude.

We learned that operations had to be well planned and quickly executed. The more quickly an abdomen was opened and closed, the less danger of infection. The fewer hands concerned in an operation the less danger of infection. We selected competent and reliable assistants and just as few as possible. Sister Catherine assisted me in operations numbering well in the hundreds as first assistant and many times the only assistant. The instruments, dressings and ligatures were close at hand. We handled them as much as possible ourselves. Operations often went on from start to finish without a spoken word, instruments and ligatures to hand promptly. We had to make things move.

I could name a long list of Sisters who by sheer ability and the will to do helped at an early date to raise our hospital to a high plane of service. Our Mother Superior finding that nursing and hospital practice was becoming highly technical, allowed me to start a course of lectures for the Sisters. For that purpose we erected a rather spacious amphitheater which was also used for the frequent clinics given at the hospital. Were the Sisters willing to attend these lectures? Not only were they willing, but eager to gather information. I had an enthusiastic class! Some of the students still have their notes taken at these lectures. A number of the Sisters had just come from Germany and did not yet understand English, so the lectures were delivered one night in English and the next night in German. This was the beginning of our nurses' school.

We introduced cotton gloves in the operating room to be worn by operator and assistants. They were easily sterilized and could be changed many times during the operation. More perfect sterilizing apparatus were installed as they developed. We installed a laboratory in a room next to the operating room, equipped for chemical and microscopic work. We began to test the efficiency of our sterilizing apparatus by taking pieces of dressings from the sterilizer packs for bacteriological investigation. We made similar examinations of the hands of the assistants and operators. Rubber gloves had not yet been introduced. This laboratory became the nucleus for our present excellent department of pathology.



From the description given in our German literature we had an X-ray apparatus constructed and as soon as we would get a Crooks tube we tried it out. It worked. We could see the bones of an arm or leg if the individual was not too fat. Soon X-ray apparatus was to be had in the market. One such X-ray outfit was promptly installed. This was turned over to Sister Tianella. There were no roentgenologists in that day. Sister Tianella became an expert technician in X-ray work and has been engaged in this work up to the present time.

We kept case histories and records, all carefully indexed. Case histories were not obligatory at that time. Oxygen and gas anesthesia were used at an early date, as was also local anesthesia. I am thinking of our first major operations under then new local anesthetic, novocaine. At a medical meeting in a neighboring city I was asked if our hospital was using local anesthesia and with what success? I related this experience to them by way of illustration. The story hinges on the fact that I did not know just when farmers sow their wheat. An elderly man with a large incarcerated hernia which had suddenly became strangulated—nephritis with a cardiac lesion and some respiratory embarrassment. A thoroughly bad surgical risk. We did a nerve blocking and proceeded to operate. I was disturbed because of his physical condition and kept up a running conversation with him while I was operating, by way of keeping informed as to how he was standing the ordeal. I asked him his name as I made the skin incision. While making the deeper dissections I asked him where he lived, how old he was, and other questions, all of which he answered cheerfully with his more or less embarrassed respirations. As I was delivering the incarcerated bowel through the open hernial sac I asked him, "What is your occupation?"

"A farmer," he replied.

"I suppose you have your wheat in by this time?"

"Hold up! Hold up!" he cried.

"Am I hurting you?"

From a talk before 1933 convention, Indiana Conference, Catholic Hospital Association.

"No, you are not hurting me. Are you operating on me?"

"Yes, and the operation is just about over."

"Well," he said, "if you don't know any more about operating than you do about farming I'm in a sorry fix, that's all!"

As early as 1915 there were 75 milligrams of radium in the hospital. The Sisters, ever mindful of the growing demands of medicine and surgery, in a spirit of progress and service, had established with the profession as well as with the laity a reputation for their hospital of which they could rightfully be proud.

Indiana Catholic Hospitals Meet

The 1933 convention of the Indiana Conference of the Catholic Hospital Association at Fort Wayne was a well attended and most enjoyable and profitable gathering. Visitors were welcomed by the mayor and others including representatives of St. Joseph Hospital where the session was held. In addition to the formal discussion of various topics of special interest to members, there was a banquet at which addresses were given by Bishop John F. Noll of Ft. Wayne, Dr. E. T. Franklin, superintendent of Methodist Hospital, Ft. Wayne, E. C. Moeller, superintendent of the Lutheran Hospital, Ft. Wayne, and others, as well as a public meeting at which in addition to various addresses, there was a showing of the film, "Good Hospital Care."

Stress was laid on some of the religious aspects of hospital service and nursing education, and in connection with the address of Rev. P. M. Butler, chaplain, St. Joseph's Hospital, it was brought out that one study of the newly admitted students of various Catholic schools of nursing in Indiana showed that the average number of students receiving any religious instructions was 32 per cent. The suggestion of Father Butler about teaching religion to student nurses was accepted in principle with details to be worked out by the committee of chaplains and the executive board of the Conference.

The convention opened with Solemn High Mass in the Cathedral.

The Woman's Auxiliary of St. Joseph Hospital was hostess to the visitors for an automobile tour of the city, and the Irene Byron Sanatorium was host at an inspection and luncheon.

Sister Mary Reginald, superintendent, Mt. Mercy Sanitarium, Hammond, as president of the Conference, had much to do with the preparation of the program and with the general success of the meeting. An important activity during her term was the revision of the constitution and by-laws which were adopted until the next meeting.

Sister Reginald was re-elected president, as were the vice-president, and secretary and treasurer, who are, respectively, Sister Mary Odilo, St. Catherine's Hospital, East Chicago, and Sister Mary Florina, St. Margaret's Hospital, Hammond. Members of the next executive board include Sister Mary Rose, Sister Mary Polycarp and Sister Mary Berchmans.

State Rulings on Hospitalization

According to a recent issue of the bulletin of the American Medical Association, on request of a representative of that organization, rulings in regard to insurance aspects of group hospitalization plans have been obtained from state insurance authorities as follows:

Are Insurance Contracts:
- Alabama
- Arkansas
- Florida
- Georgia
- Idaho
- Indiana
- Iowa
- Maryland
- Michigan
- Mississippi
- Nebraska
- New Mexico
- New York
- Oklahoma
- Oregon
- Pennsylvania
- Rhode Island
- South Dakota
- Utah
- Vermont
- Wisconsin

Are Insurance Contracts with Certain Qualifications or Limitations:
- Kansas
- Maine
- Missouri
- Tennessee
- Texas
- Virginia
- West Virginia

Are *not* Insurance Contracts:
- Arizona
- California
- Connecticut
- Kentucky
- Massachusetts
- Minnesota
- Montana
- North Carolina
- North Dakota
- Ohio

Evasive or Indefinite Opinion:
- Delaware
- Nevada
- New Hampshire
- New Jersey

No Ruling or Opinion:
- District of Columbia
- Wyoming

Awaiting Opinions:
- Colorado
- Illinois
- Louisiana
- South Carolina
- Washington

LENGTHENS COURSE

The annual report of Peter Bent Brigham Hospital, Boston, Mass., says:

"In the dietary department, the student dietitian course was increased from six to eight months to meet the standards laid down for the practical training of students by the American Dietetic Association. Twelve students completed the training as hospital dietitians during the year. The total special diet days were 13,980 as compared with 13,994 last year. The outstanding diets and numbers were: diabetic, 3,623; high caloric, 2,310; obesity, 1,822; standard nephritic, 650; low protein, 722; Sippy, 1,270."

Modernized Power Plant Saves $16,000 a Year for Salt Lake Hospital

By SOREN J. JESPERSEN

Chief Engineer, Latter Day Saints Hospital, Salt Lake City, Utah

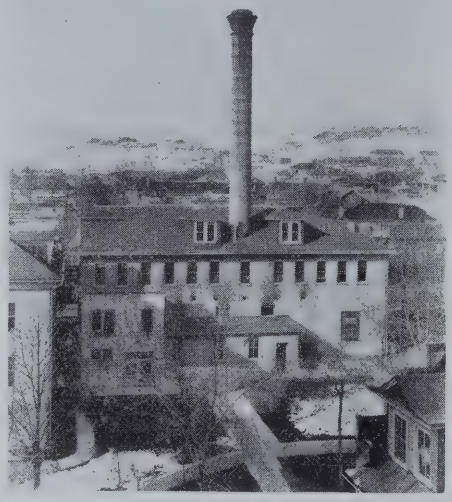
A STUDY of a hospital from the angle of mechanical equipment and modern appliances reveals that in this field of human endeavor the machine age has made itself much more manifest than generally understood.

Inasmuch as the chief mechanical requirement of a hospital may be said to be an adequate and dependable supply of steam and electric current at the lowest possible cost, leading institutions are now taking advantage of the peculiar and almost ideal balance found in most hospitals, between "generated" power and the use of exhaust steam.

Such requirements can only be met by the perfect coordination of a smooth working mechanical department, with an efficient personnel, willing and able to shoulder the repsonsibility of giving life to the buildings themselves as it were, by efficiently operating the equipment which night and day supplies power, light, water, heat, and ventilation.

Supervision of this department should be placed in the hands of a person with sufficient knowledge of the design, construction and operation of steam and electrical machinery to keep the units in repair under all variety of conditions, and to secure the best results in practice, from both complicated and simple equipment. He should be a good organizer, able so to arrange the work under his supervision that all delays and misunderstandings may be avoided, and he should be willing and intelligent enough to avail himself of all possible information pertaining to the latest developments in scientific hospital equipment, taking advantage of every opportunity to enforce rigid economy without sacrificing the high standard of service so essential to the art of hospital engineering.

In regard to the personnel, it should be understood that the day of the "monkey wrench mechanic" is long past. No sane business executive nowadays will knowingly take chances with men whose attitude towards their job is shown by their doing the minimum of work in the maximum of time and who never develop any further than to be good



The power house of Latter Day Saints Hospital.

coal heavers, or at most, a greasy-looking individual running about with a monkey wrench, a pair of pliers and a worried look, acting as wet nurse to all the electrical and mechanical equipment in the place. For it is an established fact that the men in the boiler room, by not knowing what they are about, can squander more money, in the form of lost heat units, in one day than a first class collector can collect from honest debts in a week. Such men, though they would work for nothing, no one can afford to employ.

An untrustworthy person in the front office with full knowledge of the combination to the safe is a much safer individual financially than an ignorant engineer or fireman turned loose in the boiler room, with a scoop shovel to help himself to the money stored away in the coal bunkers in the form of black diamonds. In the front office the eyes of everyone are focused on the safe, and its contents are constantly tabulated, whereas in the boiler room the coal bunkers as a rule represent a pile of black dirt, always found there in rich abundance, for somebody to handle, with few paying attention to how the handling is done. Knowledge and the proper training in the performance of mechanical work is more essential today than ever before, and too much in this regard cannot be expected from the personnel of the mechanical department of an up-to-date hospital.

Economy in securing the necessary heat, power and light, one of the largest single items of expense, is causing many institutions to deviate from policies no longer found practical. In places where investigations have disclosed that steam supplied for heating and other purposes can also be used to manufacture electricity largely as a by-product, we find that inefficient and obsolete machinery is being replaced by modern power plants designed to furnish light and power to all of the buildings as a by-product of the steam requirements for laundering, cooking, sterilizing, heating, and hot water, resulting in tremendous savings as compared with former methods of purchasing such service from outside sources.

The depression caused many hospital executives to realize that the savings effected over purchased power, by generating same in an individual plant, are not merely a pipe dream but a reality. Costs are being carefully scrutinized and steps are being taken, wherever possible, to make the whole power problem more satisfactory to the hospital from an economical standpoint.

It is obvious that the mere spotting and stopping of leaks, installing of new and modern apparatus, even changing from purchased to generated power in order to attain efficiency, is one thing; to maintain it is quite another, and anyone in authority who thinks that, having complied with the above requirements, he can kiss the whole problem goodbye and leave it to its own resources, is sadly mistaken. For in bringing about economy and efficiency in supplying utility service, it is not only sufficient to stop all leaks and wasteful extravagances, but one must sit on the stopper forever after.

To illustrate the savings sometimes made possible generating instead of purchasing power and light, a few figures are here presented. Same are taken from the mechanical department records at our own institution and represent the actual cost of com-

Month	Pounds of coal. Cost	Pounds of steam generated	Cubic feet of water. Cost	Pounds of ice. Cost	No. of kilowatt-hours. Cost	Total Cost	Savings
1929—August	312,400	2,499,200	653,800	75,460	40,183		
	$437.36		$396.00	$188.65	$772.83	$1,794.84	
September	444,800	2,693,600	693,100	75,460	52,042		
	$629.93		$428.40	$188.65	$942.80	$2,189.78	
October	580,200	4,061,400	652,400	64,128	55,340		
	$812.28		$394.04	$160.32	$1,048.69	$2,415.33	
November	841,600	5,891,600	647,700	49,600	53,800		
	$1,178.80		$391.20	$124.02	$990.27	$2,684.29	
December	849,100	5,663,700	640,800	48,840	54,600		
	$1,188.60		$373.33	$122.10	$993.50	$2,677.53	
1930—January	948,250	6,612,000	601,300	37,720	53,025		
	$1,327.20		$368.53	$94.32	$981.79	$2,771.84	
Total	3,976,350	27,421,500	3,889,100	351,208	308,990		
	$5,574.17		$2,351.50	$878.06	$5,729.88	$14,533.61	
1932—August	548,600	3,752,000	640,000	78,000	43,200		
	$767.20					$767.20	$1,027.64
September	647,086	4,779,000	615,200	76,000	47,700		
	945.28					$945.28	$1,244.50
October	676,340	4,782,000	713,700	64,000	48,100		
	$948.21					$948.21	$1,467.12
November	711,885	5,076,000	694,100	50,000	46,300		
	$1,018.16					$1,018.16	$1,666.13
December	898,800	6,409,000	616,300	48,000	48,200		
	$1,257.20					$1,257.20	$1,420.33
1933—January	908,000	6,693,000	610,200	38,000	47,900		
	$1,271.20					$1,271.20	$1,500.64
Total	4,390,711	31,491,000	3,889,500	354,000	281,400	$6,207.25	
	$6,207.25				Total savings for the six months' period		$8,326.36

bined utility service over two six-month periods, during one of which all power, light, water and ice was purchased and only steam for hot water and heat generated, while during the other all of these requirements were generated in our own plant with slack coal (now the only commodity secured from outside sources) purchased in both instances for $2.80 per ton.

The two periods have been selected purposely so as to include the savings made possible by our own water system placed in operation in August, 1932.

The first steps towards these savings were taken in the early part of 1928 when our new west wing was under construction. It became evident that the old boiler plant, which then had been in operation for 20 years, would be inadequate and plans were prepared to provide an extension to accommodate a new Babcock and Wilcox water tube boiler, of the same type as the four 102-horsepower boilers then in service but to have a capacity of 204 horsepower, to be set singly with a furnace height of 11 feet 0 inch over Combustion Engineering Company's forced draft underfeed stokers, and to be connected to the concrete chimney 5 feet 0 inch inside diameter by 100 feet high, built in 1908. In order to do this, the firing floor was dropped 5 feet below the old boiler room floor line.

As soon as the addition was completed and in operation, arrangements were made to rebuild and reset the four 102 horsepower Babcock and Wilcox boilers, as two 204 horsepower boilers over Combustion Engineering Company's stokers, to duplicate the new boiler installation. All boilers were equipped with Diamond Model G-9-5 unit soot blowers and Coppus feed water regulators. By resetting the four small boilers as two large boilers, ample space for aisles between them was provided. The boiler plant now consists of three 204 horsepower B. & W. boilers, set singly with 11 foot furnace height over Combustion Engineering Company's stokers, three Diamond soot blowers, three Coppus regulators, two 7½ by 4½ by 10 inch Worthington Duplex center-packed plunger feed pumps, Cochran open feed water heater, new 8 inch steam header with three Lagonda non-return valves, and two Sims hot water heaters, each having a storage capacity of 5,300 gallons.

To handle coal and ashes, an American Engineering Company one-ton hoist with motor driven floor operated trolley to run on a 12 inch I-beam and equipped with dump bucket was furnished and installed along the front of the boilers. This bucket is loaded from the coal bin chutes when setting on the floor, is then hoisted and traveled opposite the stoker hoppers, where it is dumped. In a similar manner a bucket of ashes is hoisted and traveled into an overhead ash bin and dumped.

The alterations were completed in January, 1929, and the new boiler plant put in operation to serve the hospital with all steam requirements for heating, hot water, laundry, and sterilizer purposes. It has been described in detail, although it is old history by now, because the writer wishes to emphasize that all savings claimed above are based on a comparison with the actual performance of this new equipment during the last six months of its first year's operation.

The generating plant, consisting of two 150 kilowatt Skinner Unaflow engines, each direct connected to Westinghouse 440 volt, 3 phase, 60 cycle, A-C generators, was installed on the Skinner Engine Company's

monthly payment plan, making it possible to pay the total purchase price of $28,000 in monthly payments, representing the savings effected over purchased power. It was placed in operation February 3, 1930, each unit being of ample capacity to carry the entire hospital load, is run alternately one week at a time, the plant has operated perfectly, and up to the present time not one moment of interruption has been experienced. The total expense for upkeep and repairs to date is $60 for new governor roller bearings, and the plant completely paid off its own purchase price plus 6 per cent on all deferred payments in 30 consecutive months.

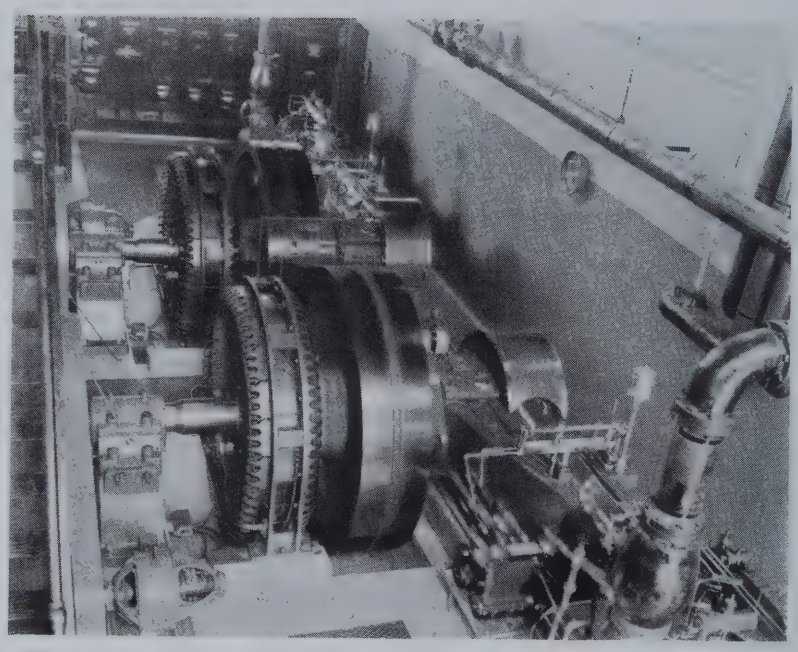
Prior to 1930 all of the hospital's ice requirements were purchased from local ice plants at a cost of $5 per ton, the refrigerating load was taken care of by a 15-ton Vilter ammonia compressor installed in 1920, with brine used as the refrigerating agent being circulated through all kitchen and hospital refrigerators. The capacity of this compressor was considered ample to take care of any additional refrigerating requirements anticipated by the then proposed new west wing. By the time this west wing was built, however, electrical refrigeration had been so far developed that rather than extend the old brine system to accommodate the new building, it was decided to install electric refrigeration instead, and in so doing take advantage of the extra capacity of the ammonia compressor by utilizing same for ice making purposes. Accordingly, a 1½ ton ice making plant was installed and since same was placed in operation all further expenditures for ice have been entirely eliminated.

Although the hospital is situated on a hill overlooking the city of Salt Lake from an altitude of 350 feet above its main street, it was thought possible because of the much greater altitude of the snowcapped hills of the Wasatch range edging the eastern border of Salt Lake Valley, that even here an underground water source of ample capacity to supply the hospital's needs might be developed. In January, 1932, prospecting for water was commenced by drilling on the hospital property.

A 12 inch casing was used for the first 100 foot depth, when it became necessary to reduce to 10 inch casing, which was used for the next 200 foot depth. Here again the casing was reduced, this time to 8 inch, which was used until the well was completed at a total depth of 470 feet. Water of excellent quality was encountered at the 400 foot depth, but the additional 70 feet was drilled to accommodate the unknown drawdown expected to develop with pumping the well. With all drillings completed, a size 8-L. C., Type YN, 20-stage Pacific deep well turbine pump, driven by a 25 horsepower, 440 volt, 3 phase, 60 cycle, U. S. motor, was installed. The length of the pump column is 420 feet; length of the 20 pump stages, 12 feet, 4 inches; suction pipe, 10 feet, and suction strainer, 1 foot, 6 inches, making the total depth of the pump 453 feet, 10 inches. Water is now being pumped at the rate of 129 gallons per minute from a depth of 380 feet to a height of 24 feet above the surface, where it is discharged into a 25,000 gallon steel reservoir, from where, in turn, it is supplied to all buildings by the aid of a 10 by 6½ by 12 inch outside center-packed National Transit steam pump at a pressure of 125 pounds.

This ends a tale of how our hospital, after formulating and putting in practice a program for the supply of all its own utility service, is now realizing in actual savings, based on the obtained results referred to in the tables above, the attractive sum of $16,000 annually, a tale which could never have been told, but for the remarkable economies made possible by the installation.

The very fact alone that water is being pumped electrically from a 500 foot well at the rate of 129 gallons per minute contributing almost $5,000 as its share of the above named savings, is one feature which anyone must admit would have been utterly impossible with purchased power.



View of equipment, showing compactness of the installation.

Dietary Activity at Holyoke Hospital

"The dietary department served, during the year, 196,793 meals, 575 meals per day. The approximate average cost per meal per person for raw food was 12½ cents or 37½ cents per day per person. This was 13½ cents a day less than the previous year," says the latest report of Holyoke Hospital, Holyoke, Mass.

"There were 18 distinctive types of special diets ordered as follows: diabetic, 904; anemic, 119; low protein, 650; reduction, 584; Sippy, 108; high calcium, 141; jaundice, 39; high protein, 57; colitis, 27; anti-constipation, 81; Karell, 1; without fat, 55; typhoid, 49; antirachitic, 106; intestinal obstruction, 26; convalescent Sippy, 317; ketogenic, 29; cardiac, 8; specials unclassified, 217. This makes a total of 10,563 meals or an average of 28 special meals per day.

"The dietitian has visited the patients frequently and given 60 hours of classwork in cookery and dietotherapy to the student nurses.

"She has also helped somewhat with the nutritional work in the clinic, especially in planning out balanced diets for the numerous clinic patients who are finding it difficult, with their limited budgets, to get the right sort of food."

O. P. D. VISITS 67 CENTS

The University of Pennsylvania Hospital, Philadelphia, reports a total of 118,088 out-patient visits for the past year at an average cost of 67 cents. This was a reduction of two cents per visit compared with the period ending May 31, 1932. Mary V. Stephenson, R. N., is superintendent of the hospital.

How Much Protection Does Liability Insurance Contract Provide?

By HARRY A. PREVOST

THE selection of insurance that provides the expenses of defense and pays losses incurred in unsuccessfully defended claims and suits brought by former patients is a procedure which requires careful action of hospital authorities.

After deciding that need exists for such protection as discussed in the preceding article,* the purchaser of an insurance contract must consider three general points: First, the insurance company to be chosen; next, the coverage of the policy offered, and finally, the cost of the protection. Obviously these three points are completely inter-related.

Too much depends upon satisfactory results to buy a policy from the agent of any company at a venture just because the cost seems nominal and is within the limit of what appears to be a justified expenditure in the hospital's budget. For the years which develop no claims, the premium may seem too much or it may seem adequate; if there are claims of serious import and the insurance does not meet expectations, it is too late to reconsider an ill-advised selection and premium expenditures are not only so much wasted money, but of more importance is the serious loss to the hospital from an adverse verdict giving large damages and perhaps an undeserved loss of reputation from an incompetent defense.

What qualifications must be demanded in selecting the insurance company itself? It must be one showing by its past history that it is stable, that it has a reputation for conservatism, that its assets are adequate, that in these times especially it is able to weather the storm of financial difficulties. Is it licensed to operate in the state where the hospital is located? This is an important point. If it is not and there is any dispute between the hospital authorities and the insurance company which results in a deadlocked opinion and the hospital must go to the courts for protection, it must be remembered that such action can only be taken in the state where the company is incorporated, usually where its headquarters are located or else in the nearest state where it is licensed. Such long range procedure is always troublesome and costly. Of course, it is not expected that such an unfortunate situation will arise. It is desirable, though, to anticipate the remote possibility and guard against the situation which has been described by insuring in a locally licensed organization.

It is also desirable to insure in a company which has a local agent of ability and sound reputation among his fellow-business men. True, the agent does not settle claims nor guide the opinion of the company in selecting competent attorneys and planning the defense, but the agent is the personal representative of the company; he adds the personal touch and, dependent upon his ability, can do much or little in constituting a fair balance wheel between his clients and his company. His own business success depends upon his ability and willingness to give good service in little matters as well as large ones. If he lives up to his requirements he must meet these obligations.

Does the company the agent represents have an able and well organized claim division, including experienced investigators and attorneys familiar with the intricacies of the defense of professional liability suits?

There are but few insurance companies writing a large volume of this form of protection. It is essentially different from automobile and other kinds of liability insurance and requires special knowledge and experience in handling the claims which develop. Some companies accept this insurance as what is called an "accommodation" line; that is, they do not seek it, but write it only to please an agent or prospect and for the purpose of obtaining or retaining other kinds of insurance. Here the volume must be small and hence the experience inadequate.

Where is the nearest branch office or claim organization of the company? Here it is that the quality of the hospital's protection is likely to develop. The closer to the institution, the better the likelihood of able familiarity with all local conditions.

Does the same company insure many physicians and dentists for their professional liability? If so, the probability is favorable to the selection of such a company.

Now for the policy itself. Competition has to a great extent standardized professional liability contracts of insurance, but occasionally there may appear a policy with some defect of coverage which may be, and probably is, reflected in the lower premium at which it is offered.

The insuring clause is the most important part of the contract, as all the following conditions, whether to the advantage of the assured or limiting the coverage, are controlled by the insuring clause. Does it provide protection only if the claim is made against the named hospital or is it broad enough to protect individuals who may have such a financial or other interest in the hospital that there is a real possibility that suit may be brought against them individually or severally or they may be joined with the hospital in the suit? Consider carefully the exact wording of the insuring clause specifying the conditions of alleged "malpractice" necessary for coverage. Are they limited by the phrase "bodily injuries"? Some claims may be outlawed by such phraseology. It is a survival of policies of a decade ago, which might have been adequate in their day but not since the public and its lawyers became expert in modern litigation against the professions. Does it cover occurrences in the hospital's out-patient department, the results of emergency treatment by the hospital's representatives while the patient is in the hospital's ambulance or other vehicle of transportation?

Simplicity is desirable in the insuring clause as well as in the rest of

*See HOSPITAL MANAGEMENT, February and May, 1933.

the contract. Sometimes the effort to detail every condition covered indicates the possibility of lack of coverage if other conditions are involved. Are autopsies covered? Some policies can be interpreted to operate only when the alleged injuries occurred to a living patient. If the hospital is forced to sue a reluctant former patient to obtain the payment of honestly earned fees and then the patient files a "counter-suit" alleging malpractice to avoid payment, will the policy protect? Will it protect when the claim is based on "breach of contract" when the contract is an ethical but definite one or merely "implied"?

Frequently there are two suits brought; one by the patient or in behalf of the patient for damages due to the alleged injury itself, the other by someone having a personal interest in the well-being of the patient, such as a husband, wife, parent or child and this suit is called "for loss of services," "loss of support," or sometimes "property damage," strange as the last phrase may seem to the layman. Does the policy under consideration assume protection for both these suits, and if so, does the amount of the policy limit the indemnity provided? For example, if it is a $5,000 policy and the patient obtains a verdict of $4,000 and the husband one for $2,000, or a total of $6,000 for both, will the policy pay the full amount or only $5,000 for both?

Most policies have two limits of indemnity or the amount of damages paid. The first limit applies as a maximum for "any one injured person" or for "any one claim or suit." Here notice the broader inclusion of the last phrase which would protect fully in the foregoing example while the first would limit the total paid to $5,000 as explained. The second limit of the policy is usually, though not necessarily, three times the amount of the first limit. The policy should state that this second limit includes the total of all claims paid in any one policy year. If it does not, it may be considered as a "permanent" limit and applicable to the full life of the policy, no matter how many years it may be renewed. Its value is accordingly, much diminished. It is seldom that any institution is so unfortunate as to incur such a number of unsuccessfully defended damage suits that the second limit may become operative, still the possibility exists and the best coverage obtainable for such conditions should be demanded.

Does the policy define the nature of the positions of the hospital's employes and their assistants who must be the persons alleged at fault when protection is operative under the policy? Does it protect, for example, if the proceedings state that the injury was caused directly by some person not employed by the hospital but acting in an emergency by assisting an intern, nurse or other recognized hospital employe? The occasion may have fully warranted the conditions but make sure the policy will protect if a claim develops.

Does the policy assume the payment of all costs in the investigation, preparation and defense of each claim and suit or put some form of limitation on this?

All policies must contain provisions and agreements defining and limiting the action of both parties to the contract. Make sure that those relating to the assured are reasonable and definite and that the insurance company does not assign to itself any rights which in practice may be unfair to the interests of the hospital.

If the policy provides that compromise settlement may be effected rather than trial through the courts, which party, the hospital or the insurance company, holds the right of decision? If the policy does not include the right to compromise, how is the contract interpreted in case it is the opinion of the hospital's authorities that it is best for their interests to avoid public litigation?

The hospital is likely to be told that when a policy contains the right of compromise clause, the insurance company is prone to attempt such a settlement in nearly every case, and while it cannot do so without the hospital's written consent, will attempt to persuade the authorities to give such approval. This is a gross exaggeration. Should such methods be followed generally by the insuring companies, their losses would soon so exceed their premiums that, to save themselves, discontinuance of hospital liability insurance would be obligatory. In actual practice it has been found, unfortunately for the best interests of both the hospitals and the companies, that the former are indeed likely to desire settlement in many cases where the company wishes to defend to the court of last resort. This attitude to avoid publicity may be a natural one, but in the long run is likely to lower the ethical standing of hospitals in public opinion. Of course, as a last resort, the insurance company has the balance of power. If it wishes to fight the case and the hospital desires to compromise, the company can insist upon defense but it handicaps its own position in forcing a reluctant patron into court and as a matter of practical procedure rarely can insist upon its technical policy rights beyond a certain point. Still the policy lacking the compromise settlement clause gives every right of procedure to the insurer and may in general be the most desirable form of contract for all concerned.

Occasionally, though infrequently, a plaintiff's attorneys choose to sue the hospital's representative or employe only, that is, the person considered actually to have committed the act or omission or join this person in a suit against the hospital. The reasons for doing this may vary; the hospital may be a charitable one and considered judgment proof; it may be thought that popular opinion would not favor a verdict against the hospital itself but would against an individual, or perhaps it had been learned that the individual has sizable resources and they are more accessible to collection than the hospital's own funds. True, if the hospital is not sued, it is not directly concerned, but let us hope that every hospital has a real interest in the well being of its professional personnel and therefore would not wish the resources of such persons hazarded in the performance of professional obligations. Does the policy extend its protection to the individuals in such suits?

Some policies cannot be canceled either by the insurance company or by the insured hospital during the annual term for which the policy has been approved by the company and the premium paid by the insured. Some permit cancellation by the company with return of premium for the unexpired term, but the hospital does not enjoy this right. Finally, some policies contain the right of cancella-

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tion by either party to the contract, subject to premium adjustment. In such contracts, the company retains a certain part of the premium beyond the amount returned for the unexpired term, as a fee for their overhead expenses in underwriting and issuing the policy. In actual practice it is seldom that a company, having once accepted an application based on a true and full statement of facts necessary for underwriting and premium rating purposes, cancels for any cause during the annual term. If the claim experience indicates that continuation of the insurance will be at constant and repeated losses, the company usually contents itself with refusing to renew the policy.

Having now discussed the answers to require to our questions of insurance carrier selection and policy coverage, we now arrive at the actual purchase of the contract. What does the company ask in taking the application and upon what does it base its calculations of premium?

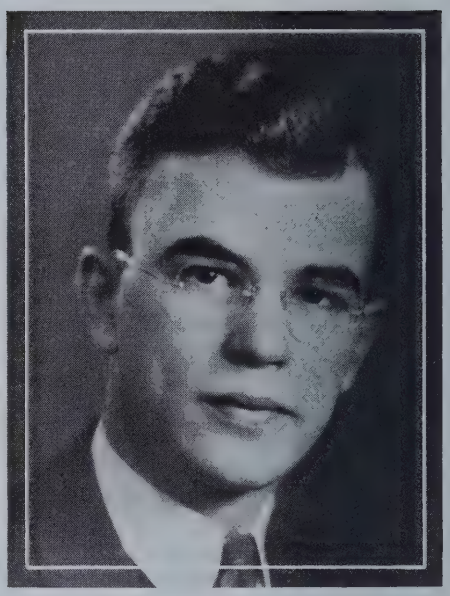
Primarily, we must dismiss from our consideration the insurance companies that do not endeavor to maintain a careful underwriting selection of reasonably sound risks. We maintain that our institution ranks among them and we do not intend to contribute premiums for the losses sustained by improperly organized and managed hospitals which may be insured by too generous companies with short sighted eyes upon increased rather than profitable business. Neither do we wish to be charged a rate averaged by general experience in insuring even the generally better hospitals, if our own is in a class likely to produce the fewest and less dangerous damage suits. We must ask a rating commensurate with the hazard involved, although willing to pay value for value received. If our house is of wood construction we know our fire insurance rates must be higher than for a brick or stone edifice, no matter how soundly we built or how careful we are in protecting our property. So, we also know that the small private hospital, primarily operating for profit, is at one end of the scale of hazard in damage suits from patients and the large charity hospital with resources protected by statutes from the same kind of claims at the other, with gradients between. Therefore, the premium should be based, first of all, upon the kind of hospital, after it is shown that otherwise it is a desirable risk, proved by the character of its staff, the quality and sufficiency of its employed personnel, its equipment and conduct in operation.

All else being satisfactory, the premium should favor the larger hospital in considering the "bed charge," which is the basis and usually the larger part of the premium. Some companies apply this to the total number of beds maintained; others to the average occupancy. The success of the hospital, so far as indicated in the direction of maximum occupancy, establishes the choice between these two ways of charging bed rates for insurance.

In closing this series of articles, perhaps a word of advice towards accepting recommendations and analysis of the insurance offered may be in order. Let each company explain and recommend its own proposal, but beware of explanation or criticism of its competitor's offerings beyond a very reasonable and modified extent. There are ethical practices in insurance just as in medicine. The physician of standing will defend his methods and ability; he will not unduly attack those of other practitioners. Neither should the better insurance companies or their representatives depart from this sound and dignified rule of conduct. Let each proclaim the advantages of its own wares—this is its natural right—but let adverse opinion be the right of the purchaser of insurance, the hospital, and any disinterested and competent critic to whom it may turn for advice. Here the lawyer of experience and ability plays an important part, also the advice of other hospitals and physicians having had insurance of similar kind and consequently experience with the adequacy of the policies and the ability and willingness of the different companies in giving their service in time of need.

SURGICAL TRADE CODE

Shortly after the first of the year adoption or approval of the code of fair competition for the surgical trade under the National Recovery Act is expected. Hospitals are vitally interested in this code, especially in regard to its possible effect on prices. In this connection HOSPITAL MANAGEMENT asked F. B. Hovey, secretary of the American Surgical Trade Association, to comment on the proposed code, and in reply Mr. Hovey said, "In my opinion the code will have very little effect on hospitals due to several factors including the depreciation in the foreign value of American money which has made surgical instruments, which are practically all imported, higher in price. The shortening of hours and the increase in wages due to the President's Reemployment Agreement has already increased the cost of some of the items sold by the surgical trade to hospitals. I doubt if the code itself will have much, if any, effect in increasing these costs."



RICHARD B. BENSON

Richard Benson Takes Post at Omaha

Richard B. Benson, son of Dr. John G. Benson, general superintendent, Methodist Hospital, Indianapolis, on December 1 became business manager of the Omaha Methodist Hospital, Omaha, Nebr. Young Mr. Benson has had an unusual opportunity to become familiar with principles and practices of hospital administration, working with his father when the latter was in charge of White Cross Hospital, Columbus, while completing his studies at Ohio State University.

Later young Mr. Benson became associated with the Methodist Hospital, Indianapolis, where he familiarized himself with details and routine in numerous departments, and where he also organized a department of social service and statistics.

The new business manager also had an opportunity to attend a number of conventions, and was a student at the Institute of Hospital Administration of the American Hospital Association.

Rev. Harry E. Hess is superintendent of the Omaha Methodist Hospital.

A. H. A. SECTION CHAIRMEN

Lena Cooper, director of dietetics, Montefiore Hospital, New York City, who is chairman of the dietetic section of the 1934 American Hospital Association convention, hopes to have a program of practical interest to hospital administrators as well as dietitians. She will be assisted in the arrangement of the program and in the conduct of the section by Mable MacLachlan, University of Michigan Hospital, who is secretary of this section. A number of other sections of the American Hospital Association re-elected 1933 officers, including the Small Hospital Section, the Out-Patient Section, Administration Section and the Construction Section.

Every Detail Clear

THE most carefully written description may leave some details hazy. Even trained writers often fail in creating exact pictures in their readers' minds.

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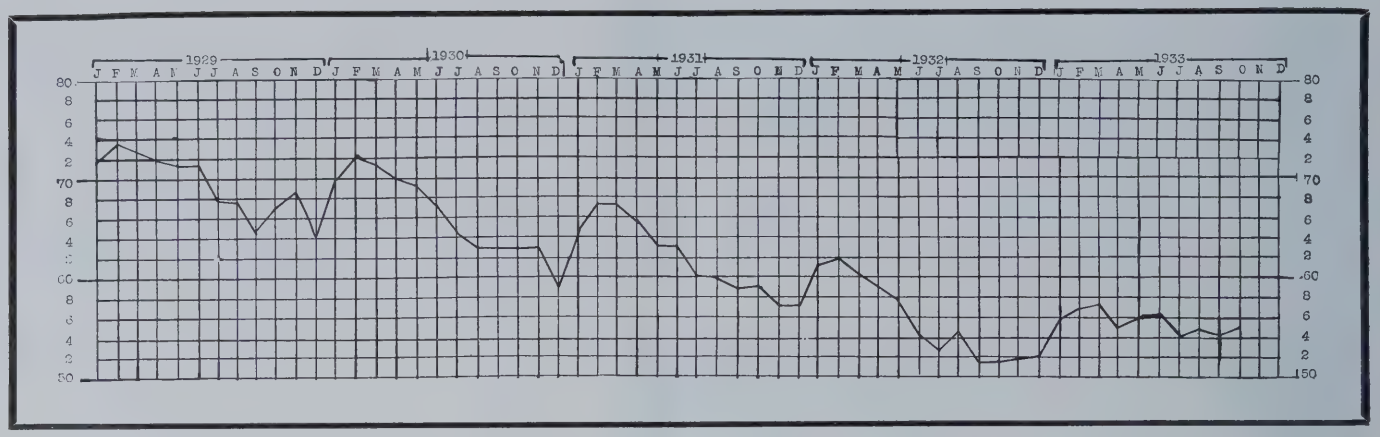


This graph shows the percentage of occupancy in 91 general hospitals in 87 communities in 35 states, with a basic bed capacity of 16,922.

Total Daily Average Patient Census

January, 1929	11,919
February, 1929	12,335
March, 1929	12,253
April, 1929	12,114
May, 1929	11,981
June, 1929	12,025
July, 1929	11,473
August, 1929	11,548
September, 1929	11,157
October, 1929	11,590
November, 1929	11,736
December, 1929	10,977
January, 1930	12,048
February, 1930	12,425
March, 1930	12,408
April, 1930	12,128
May, 1930	12,044
June, 1930	11,601
July, 1930	11,290
August, 1930	10,997
September, 1930	11,015
October, 1930	11,086
November, 1930	11,005
December, 1930	10,524
January, 1931	11,510
February, 1931	11,991
March, 1931	11,970
April, 1931	11,669
May, 1931	11,251
June, 1931	11,187
July, 1931	10,765
August, 1931	10,657
September, 1931	10,409
October, 1931	10,499
November, 1931	10,266
December, 1931	10,145
January, 1932	10,758
February, 1932	11,038
March, 1932	10,888
April, 1932	10,596
May, 1932	10,082
June, 1932	9,927
July, 1932	9,571
August, 1932	9,748
*September, 1932	9,125
*October, 1932	9,226
*November, 1932	9,328
December, 1932	9,403
January, 1933	10,037
February, 1933	10,197
March, 1933	10,222
April, 1933	9,957
May, 1933	10,004
June, 1933	10,023
July, 1933	9,786
August, 1933	9,809
September, 1933	9,716
October, 1933	9,883

Receipts from Patients

January, 1929	1,795,843.79
February, 1929	1,776,040.82
March, 1929	2,024,823.11
April, 1929	1,929,175.70
May, 1929	1,920,982.43
June, 1929	1,874,173.11
July, 1929	1,846,899.32
August, 1929	1,867,706.24
September, 1929	1,772,230.39
October, 1929	1,828,051.39
November, 1929	1,786,036.71
December, 1929	1,737,404.65
January, 1930	1,840,418.05
February, 1930	1,799,080.00
March, 1930	2,003,309.58
April, 1930	1,927,493.30
May, 1930	1,921,523.05
June, 1930	1,817,813.00
July, 1930	1,803,315.00
August, 1930	1,719,634.00
September, 1930	1,700,314.00
October, 1930	1,741,017.00

"How's Business?"

November, 1930	1,640,374.00
December, 1930	1,687,813.00
January, 1931	1,771,812.00
February, 1931	1,720,474.00
March, 1931	1,881,003.00
April, 1931	1,831,228.00
May, 1931	1,815,096.00
June, 1931	1,743,189.00
July, 1931	1,698,277.00
August, 1931	1,598,869.00
September, 1931	1,555,436.00
October, 1931	1,583,005.00
November, 1931	1,497,948.00
December, 1931	1,521,552.00
January, 1932	1,527,159.00
February, 1932	1,468,059.00
March, 1932	1,574,446.00
April, 1932	1,496,077.00
May, 1932	1,453,746.00
June, 1932	1,417,856.00
July, 1932	1,357,096.00
August, 1932	1,327,016.00
September, 1932	1,244,635.00
*October, 1932	1,248,504.00
*November, 1932	1,206,405.00
December, 1932	1,258,672.00
January, 1933	1,331,825.00
February, 1933	1,234,741.00
March, 1933	1,271,784.00
April, 1933	1,284,895.00
May, 1933	1,342,120.00
June, 1933	1,333,867.00
July, 1933	1,290,472.00
August, 1933	1,310,558.00
September, 1933	1,283,945.00
October, 1933	1,304,642.00

Operating Expenditures

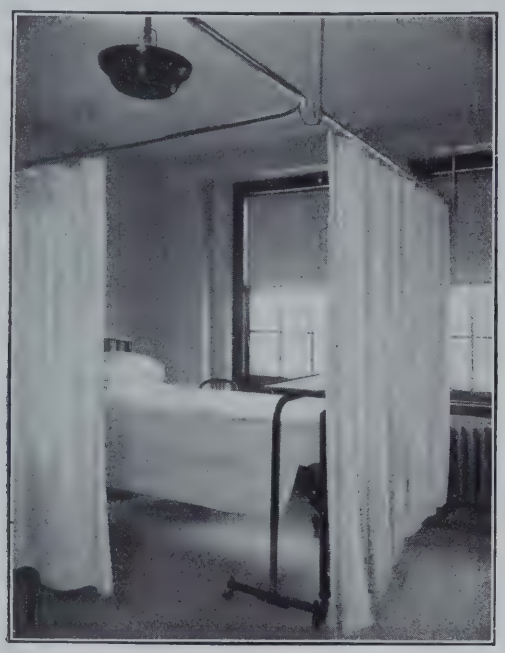
January, 1929	2,104,552.74
February, 1929	2,007,945.24
March, 1929	2,099,208.11
April, 1929	2,071,386.46
May, 1929	2,064,381.77
June, 1929	2,034,409.13
July, 1929	2,045,112.96
August, 1929	2,068,388.63
September, 1929	2,050,510.38
October, 1929	2,079,042.06
November, 1929	2,091,089.31
December, 1929	2,127,053.36
January, 1930	2,190,909.95
February, 1930	2,067,112.17
March, 1930	2,120,861.86
April, 1930	2,064,328.56
May, 1930	2,102,407.49
June, 1930	2,027,258.00
July, 1930	2,038,042.00
August, 1930	1,985,045.00
September, 1930	2,079,154.00
October, 1930	2,033,163.00
November, 1930	2,003,297.00
December, 1930	2,031,148.00
January, 1931	2,058,681.00
February, 1931	1,963,391.00
March, 1931	2,026,363.00
April, 1931	1,976,430.00
May, 1931	1,967,866.00
June, 1931	1,932,832.00
July, 1931	1,925,156.00
August, 1931	1,870,985.00
September, 1931	1,890,891.00
October, 1931	1,885,424.00
November, 1931	1,829,539.00
December, 1931	1,889,887.00
January, 1932	1,806,279.00
February, 1932	1,763,572.00
March, 1932	1,762,657.00
April, 1932	1,733,486.00
May, 1932	1,672,550.00
June, 1932	1,607,822.00
July, 1932	1,590,274.00
August, 1932	1,565,767.00
*September, 1932	1,508,519.00
*October, 1932	1,515,582.00
*November, 1932	1,488,989.00
December, 1932	1,568,845.00
January, 1933	1,546,747.00
February, 1933	1,490,075.00
March, 1933	1,585,755.00
April, 1933	1,531,870.00
May, 1933	1,536,710.00
June, 1933	1,545,307.00
July, 1933	1,555,554.00
August, 1933	1,555,701.00
September, 1933	1,579,869.00
October, 1933	1,611,151.00

Average Occupancy on 100 Per Cent Basis

January, 1929	71.6
February, 1929	73.8
March, 1929	73.2
April, 1929	72.2
May, 1929	71.2
June, 1929	71.3
July, 1929	67.8
August, 1929	67.5
September, 1929	65.0
October, 1929	68.0
November, 1929	68.6
December, 1929	64.0
January, 1930	70.1
February, 1930	72.1
March, 1930	71.8
April, 1930	70.0
May, 1930	69.4
June, 1930	66.6
July, 1930	64.7
August, 1930	62.7
September, 1930	62.8
October, 1930	62.9
November, 1930	62.4
December, 1930	59.1
January, 1931	64.9
February, 1931	67.5
March, 1931	67.2
April, 1931	65.8
May, 1931	63.0
June, 1931	62.6
July, 1931	60.3
August, 1931	59.7
September, 1931	58.3
October, 1931	59.0
November, 1931	57.5
December, 1931	56.8
January, 1932	60.2
February, 1932	61.8
March, 1932	61.0
April, 1932	59.3
May, 1932	56.4
June, 1932	55.6
July, 1932	53.6
August, 1932	54.6
*September, 1932	51.1
*October, 1932	51.6
*November, 1932	52.2
December, 1932	52.6
January, 1933	56.2
February, 1933	57.0
March, 1933	57.2
April, 1933	55.7
May, 1933	56.0
June, 1933	56.1
July, 1933	54.7
August, 1933	54.9
September, 1933	54.4
October, 1933	55.3

*One hospital closed during construction program.

Are your Private Rooms
a loss or a source of income?



In discussing the problem of balancing hospital budgets, the annual report of the United Hospital Fund says that "—trustees and administrators, faced with a shrinkage in income from patients and invested funds have been called on to enlarge their free service. **Private rooms were largely unoccupied, while the wards were full.—"**

Perhaps you are faced with these same problems—including unoccupied private rooms. If so, you can turn this present loss into an immediate source of income by dividing them into multiple bed units—by means of Day's Curtain Screening Equipment.

This modern bedside screening readily transforms private rooms into cozy two-bed and three-bed units—which enables you to **reduce** the fee per person to within reach of many patients who cannot afford the present fees and therefore have to go into wards.

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Patients in more than 350 hospitals throughout the country appreciate the privacy provided by Day's Curtain Screening Equipment. It's so clean, quick and convenient. An entire bed may be easily enclosed with one curtain. With the curtains back against the wall the rooms are as neat and light and airy as even the most fussy patient could desire.

Why not have our Engineering Department, long experienced in this type of work, study your specific requirements and submit recommendations which will assure you of an efficient and economical system of bedside screening. In the meantime, by returning the coupon, you can secure your copy of an interesting, instructive booklet, "Privacy in the Modern Hospital".

H. L. Judd Company, Inc., Hospital Division

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Your Name .....

Hospital .....

Address .....

H. M.-12-33

Some Advantages of Central Food Service

By CLARA PALAN, B. S.

Dietitian, Columbus Hospital, Great Falls, Mont.

THE food problem is ever with us. It is as old as the human race. Food is something with which we are all familiar. As a former classmate states, "Of all the departments in a hospital discussed most frequently by patients, 'ex,' present and future, their friends, relatives and 'in-laws,' the dietary problem probably heads the list." Needless to state that one in bed has more time to think of what he is going to have or did have to eat than a person up and around.

By what route does the tray reach the patient from the kitchen? Of the possible methods, the central food service is the one we will consider.

Now, what is a central food service? Generally speaking, "Central food service is any system where the individual patients' trays are completely prepared and made ready collectively under the constant supervision of the dietitian or her personnel." The finished tray as it is delivered to the patient should concern the dietitian and be solely her responsibility to the very end.

The bulk preparation of food need not be at the same place as the tray set-up and distribution. In fact some hospitals have found that where these two branches of the work were definitely divided they were very satisfactory.

Having stated what we mean by central food service, what factors must be considered in the successful working of such a plan, and what are its advantages over the floor kitchen type?

For the success of any food service co-operation and a decrease in help turnover are very essential. You must have co-operation among the dietitian, the kitchen personnel, Sisters in charge of the floors, those delivering the trays to the patient—and, yes, the patient himself.

The length of time during which the entire food service is in progress is really immaterial. For example, we serve from 125 to 145 patients in, say, 40 minutes. Of what importance is that? None whatever. The length of time it takes each individual tray from the time it is completely set up until it actually reaches the patient is the important factor. This means the food must travel the shortest and quickest route so that the food will be hot or cold, as the case may be, and in its most palatable state. This means the patient is ready for his tray when it actually arrives. It also means that someone is ready to take the tray from the elevator, cart or lift as soon as it reaches the floor. If these were all taken care of, surely it would shorten the time it takes each individual tray to reach its destination. If the trays would reach the floor at the same time each day or if those in charge knew exactly when the trays would be served this would possibly take care of those few minutes that the trays would otherwise have to stand before being served.

What is your labor turnover per month for your dietary department? What is it in your 30-bed hospital? What is it in your 290-bed hospital? It is too high. If you have help that is efficient and mentally alert, it makes for greater efficiency in time and money, less breakage of dishes and better care of equipment. For these reasons alone, wouldn't you like to see labor turnover at a minimum?

Miss Ray, a dietitian from the Albany Hospital, Albany, N. Y., who has had experience with both types of food service, sums the advantages of the central food service as follows:

1. Noise, odor and grease are eliminated from the floors.

2. Nurses are relieved of all responsibility in preparation of trays.

3. Space used for ward kitchens may be used for patients' rooms. Perhaps you need more rooms in your hospital. Do you?

4. Better tray service may be given by having all the trays checked by a dietitian. She is responsible for the tray service. She hears the complaints of food service or occasionally favorable comments. Let the tray be the dietitian's finished product. If one person checks, say, 125 trays a meal or 11,250 trays a month, the trays are bound to be more standardized than if, say, five persons check at five different serving stations.

5. Less equipment is necessary and it is much more apt to be taken care of.

6. Better control of food, for supervised serving eliminates waste. There is but one serving center instead of as many as ward kitchens. Central food service should eliminate lunching in the wards; the trays served to visitors can be more easily accounted for and charged. The waste can be checked easier if in the kitchen serving center than if on the floor kitchen serving centers.

In this Albany hospital for the twelve-month period following the installation of central service raw food costs were reduced nine cents per day per person as compared to ward service. Now, if you have on the average of 20 persons per day in your hospital that would mean an actual saving of $54 per month. For 125 patients it would mean an actual saving of $337.50. If only half that amount were saved it would be well worth the money. If the dietary department spends from one-fourth to one-third of the hospital's actual income, shouldn't every measure be used for economical service?

Whether central food service or the ward kitchen type, it must be such that the patient never guesses the struggle that exists that he may get his meals on time, three times a day. The fact that the toaster burned out, that the milkman didn't arrive in time with the morning cream, that the cook is ill, are some of the bits of purgatory belonging to those who operate a food service. Appreciated trays would be an answer to any dietitian's prayer.

From a paper before organization meeting, Montana Conference of Catholic Hospitals, Great Falls, September 8, 1933.

Well—They've seen our new china, handled it, tried it

Do they like it?

Read what china buyers say

WITH lots of hope and a few doubts we launched, last month, a new China—Econo-Rim—a china that defies all pottery tradition. A china that takes the emphasis away from the pattern and puts it on the practical basis of space-saving- money-making design.

Since our announcement, Econo-Rim has had a thorough going over in the hands of hotel, restaurant, hospital, school and cafeteria people. Our booths at trade shows were jammed with men and women in all branches of the food industry. We asked for their frank opinion—favorable or otherwise. They gave it. And no china we have ever produced has had a more cordial or enthusiastic reception.

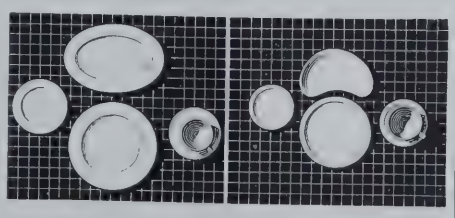
As one hotel owner, who is also an architect, said: "You people have become engineers. This design of yours is going to inject an entirely new note into hotel architecture. You've opened the way to space economies never thought of before." That's one side of it. Here's what a restaurant man had to say, "Econo-Rim fits in perfectly with my present needs for more trade in the same amount of space. It's going to let me put in more 'deuces' without overcrowding them, and every additional table means added profit. I'm for it!" So are cafeteria men "for it." They should be. For the first time the customer can go on adding to his order without filling his tray. And Econo-Rim is much easier to handle—this is true in the case of customers as well as the help.

Hospitals have warmed instantly to Econo-Rim because, as one dietitian says, "Patients on the mend sometimes feel we are trying to overcrowd them with food. Using Econo-Rim we can give them all the food they need without having the tray look overcrowded." Counter services and bars have also pointed out some features which appeal to them. One of those features is the fact that a sandwich no longer spreads out over the edge of the plate. It stays within the confines of the rim. Another advantage is the additional space Econo-Rim gives each customer on the counter. His own food is right in front of him. Now, to get down to the reasons for all this enthusiasm.

An Explanation of Econo-Rim Design

The diagrams below were traced over actual photographs of a typical present day service laid along side of the same service in Econo-Rim. Two things we want to emphasize, for Econo-Rim has a two-way advantage over present china. First, is the space-saving feature of a complete service on a table, a counter or tray. Second, is the opportunity for substituting plates with smaller over-all dimensions without cutting down the usable food area of the plate. In other words, smaller plates but the same space for food.

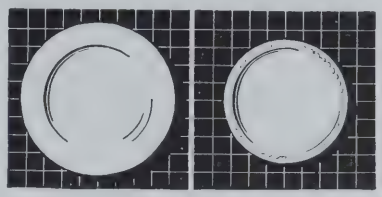
Now, before we get at the diagrams you are going to ask just how these space economies are possible—what we have done to this china. You have a clue in the name—Econo-Rim. For it is the rim of this china which sets it apart from all present day ware. Up to now rims served two purposes. Something to take hold of. And a place for the pattern. Potters stopped right there—the rim was a place for the pattern. Nobody seemed to realize that the rim could be made beautiful without an elaborate decoration. We discarded that outworn notion. We cut down the dimensions of the rim. Introduced the pattern into the center of the plate. And by simple embossing, with just enough color to set it off, we found that we had the most distinguished service imaginable. Today Econo-Rim "dresses" a table and the food itself just as tastefully as the most elaborately colored ware. At the same time it introduces practical profit-making features.



A B

Left: A typical luncheon service using a 10" plate. (Over all diameter.)
Right: The same luncheon served on Econo-Rim. Luncheon A occupies an area of 456 square inches. B, on Econo-Rim, occupies an area of 294 square inches. The saving is 34%. And the actual, usable food area of both table and set-ups is approximately the same.

Now, let's move the camera closer and see how one single plate in old-style china compares with the corresponding plate in Econo-Rim. By corresponding plate we mean that plate which provides approximately the same amount of usable food area. Here is what we have.



Left: A conventional 10" plate. Area actually occupied by food—42.8 square inches.
Right: Econo-Rim measures 8 3/16 over all. But provides actual usable area for food of 41 square inches. Or a saving in space over the 10" plate of 36.5%.

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Suggested Books for Dietitians

At the convention of the American Hospital Association the American Dietetic Association distributed leaflets entitled, "Suggestions for the Dietary Book Shelf." The following was a list of volumes and other publications:

American Dietetic Association. Bibliographies on Child Health and on Foreign Food Habits and Customs. 1932.

Blunt, K. and Cowan, R. Ultraviolet Light and Vitamin D in Nutrition. $2.50. 1930, University of Chicago Press.

Bogert, L. G. Nutrition and Physical Fitness. $3. 1931. Saunders Co.

Bowes, A. and others. List of Low Cost Dietary Data. Journal American Dietetic Association, January, 1933.

Cecil, R. L. Textbook of Medicine. $9. 1927. Saunders Co.

Child, A. M., Niles, K. B., Kolshorn, A. Food Preparation Studies with Recipes. $1.75. 1932. Wiley and Sons, Inc.

Cooper, L. F., Barber, E. M., Mitchell, H. S. Nutrition and Dietetics in Health and Disease. 4th Ed. Rev. $3. 1931. Lippincott Co.

Cooper, L. F. Nutrition in Health and Disease for Nurses. (Lippincott Nursing Manuals) 4th Ed. Rev. $3, 1931. Lippincott Co.

Dubois, E. F. Basal Metabolism in Health and Disease. 2nd Ed. Rev. $5. 1927. Lea and Febiger.

Eddy, W. H. Nutrition. $2.50. 1928. Williams and Wilkins.

Gilson, H. E. The Perfect Tray. Onondaga Pottery Co., Syracuse, N. Y.

Graves, L. G. Foods in Health and Disease. $3.50. 1932. Macmillan Co.

Halliday, E. and Noble, I. Hows and Whys of Cooking. $2. 1928. University of Chicago Press.

Harris, J. and Lacy, E. Everyday Foods. $1.56. Houghton Mifflin. 1927.

Harrop, G. A. Diet and Disease. $4. 1930. Blakiston's Son and Co.

Hawk, P. B. and Bergheim, O. Practical Physiological Chemistry. 9th Ed. Rev. and Enl. $6.50. 1926. Blakiston's Son and Co.

Hess, J. H. Feeding and Nutritional Disorders in Infancy and Childhood. 6th Ed. Rev. $4.50. 1928. Davis Co.

Joslin, E. P. Diabetes, Its Control by the Individual and the State. (Harvard Health Talks.) $1. 1931. Harvard University Press.

Joslin, E. P. Diabetic Manual. 4th Ed. $2. 1929. Lea and Febiger.

Lanman, F. R., McKay, H., Zwill, F. The Family's Food. $1.68. 1931. Lippincott Co.

Lowe, B. Experimental Cookery from the Chemical and Physical Standpoint with a Laboratory Outline. $4.59. 1932. Wiley and Sons Inc.

Lusk, G. Elements of the Science of Nutrition. 4th Ed. $7. 1928. Saunders Co.

McCollum, E. V. and Simonds, N. Food. Nutrition and Health. $1.60. 1928. 2nd Ed. The Authors. Box 25. East End Station. Baltimore. Md.

McCollum, E. V. New Knowledge of Nutrition. 4th Ed. $5. 1929. Macmillan Co.

McLester, J. S. Nutrition and Diet in Health and Disease. 2nd Ed. Rev. $8.50. 1931. Saunders Co.

Myers, V. C. Practical Chemical Analysis of Blood. 2nd Ed. Rev. $5. 1925. Mosby Co.

Pattee, A. F. Practical Dietetics. $2.75. 1929. The Author, 445 Gramatan Avenue, Mt. Vernon, N. Y.

Pattee, A. F. Teacher's Guide, containing the latest standard curriculum state board requirements in dietetics and state board examination questions. $.50. 1929. The Author, 445 Gramatan Avenue, Mt. Vernon, N. Y.

Peters, J. T. and Van Slyke, D. D. Quantitative Clinical Chemistry. Vol. I, $12. Vol. II, $8. 1931. Williams and Wilkins Co.

Pfaffman, M. and Stern, F. Food and Your Body. $2. 1932. Barrows Co.

Pope, A. E. and Geraghty, E. M. Essentials of Dietetics in Health and in Disease. 3rd Ed. Rev. and Enl. $3. 1931. Putman's Sons.

Proudfit, F. F. Dietetics for Nurses. 4th Ed. $2.75. 1927. Macmillan Co.

Proudfit, F. F. Teacher's Guide to Proudfit's Dietetics for Nurses. 3rd Ed. Rev. $.40. 1924. Macmillan Co.

Proudfit, F. F. Nutriiton and Diet Therapy. 5th Ed. $2.75. Macmillan Co.

Reeves, J., Trilling, M., Williamson, F. Problems in Food and the Family. 1931. Lippincott.

Roberts, L. J. Nutrition Work with Children. $3.50. 1031. University of Chicago Press.

Rose, M. S. Feeding the Family. 3rd Ed. $5. College Ed. $3.75. 1929. Macmillan Co.

Rose, M. S. Foundations of Nutrition. $2.75. 1927. Macmillan Co.

Rose, M. S. Laboratory Handbook for Dietetics. 3rd Ed. $3. 1929. Macmillan Co.

Rose, M. S. Teaching Nutrition to Boys and Girls. 1st Ed. $2. Macmillan Co. 1932.

Rowe, A. H. Food Allergy. $5. 1931. Lea and Febiger.

Sherman, H. C. Chemistry of Food and Nutrition. 4th Ed. Enl. $3. 1932. Macmillan Co.

Sherman, H. C. Food Products. 4th Ed. Rev. $3. 1932. Macmillan Co.

Smith, S. L. Vitamins in Food Mateials. U. S. Department of Agriculture. Circular No. 84.

Stiebling, H. K. The Iron Content of Vegetables and Fruits. U. S. Department of Agriculture. Circular No. 205.

Stiles, P. G. Nutritional Physiology. 7th Ed. Rev. $2.25. 1931. Saunders Co.

Sweetman, M. D. Food Preparation $3. 1932. Wiley and Sons, Inc.

Thoma, K. M. Food in Health and Disease. 1st Ed. $2.75. 1933. Davis Co.

Thompson, May E. and Bryan, M. Some Sources of Illustrative Material of Use to the Hospital Dietitian. Journal American Dietetics Association. June, 1931.

U. S. Department of Agriculture, Bureau of Home Economics. Nutrition Charts. Set of 9, $.50.

Wheeler, R. and Wheeler, H. American Red Cross Textbook on Food and Nutrition. $1. 1927. American Red Cross.

White House Conference on Child Health and Protection, Committee on Growth and Development of the Child. Part III. $4. 1932. Century Co.

Wilder, R. M. Primer for Diabetic Patients. 3rd Ed. Rev. $1.50. 1927. Saunders Co.

Week Emphasizes Value of Cheese

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That is the slogan of every commissary, and private dining room in the United States during December 11-16. That week was designated by the governors of leading dairy states as National Cheese Week, and according to the plan, approved by the dairy department of the United States Department of Agriculture, every family in the United States will be asked to increase its normal cheese consumption one pound during this week. By frequent and increased serving of cheese during this period, it is hoped that the tremendous surplus of cheese which exists in this country can be moved and a sound basis of recovery for the dairy industry be provided.

Cheese plays a versatile role on the hospital menu because of its wide adaptability. All good cheese is from 90 to 99 per cent digestible, so that many varieties of cheese can be used in the hospital dietary to lend variety to foods which would otherwise be monotonous. The all-milk cheese foods with their high mineral and protein values, and their exceptionally high degree of digestibility, are perfect cheeses for the daily hospital fare. One of these, Velveeta, makes the perfect sauce for vegetables, delicious omelettes, the ideal complement of macaroni, rice, and potatoes.

On the menu designed especially to tempt the invalid appetite, cheese has always been important. Almost all vegetables dressed in a rich and golden cheese sauce are more tempting to the languid taste. Cheese lends a piquancy to sauces, for fish, for chicken, that is quite magic in its stimulus. American cheese or the sharper old English variety of cheese in sauces for potatoes, macaroni and rice may be featured especially during Cheese Week. Escalloped fish, sauces for shrimp or salmon may all be glorified with the addition of cheese.

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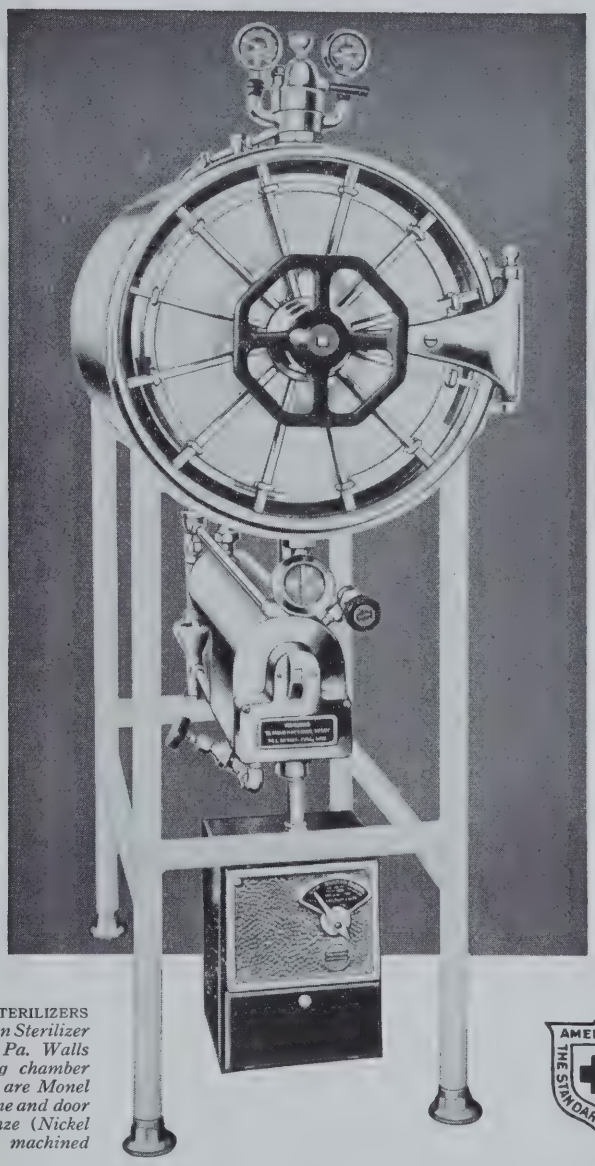

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Why Can't Nurses and Dietitians Work Together?

Nursing Viewpoint

By Mabel Humphrey, R. N.
Superintendent of Nurses, St. Luke's Hospital, Denver, Colo.

THE definition of cooperation given in the dictionary, is the act of working jointly together for the same end.

In most hospitals the past fifteen years, it could be stated as war between nurses and dietitians. The reason for this constant war is mostly with older graduate nurses or the graduate who finished training before 1918. These nurses learned to cook at home before entering nurses' training or as some might say, they had a natural instinct for cooking. Some schools did not have trained dietitians before the war, for during that time the dietitian came into the private hospital. We will say the large training school has for the past ten years tried to employ the best trained hospital dietitian available.

Why do we have trouble with the nurse—is she right or wrong? You might say: "Why does she worry? It is less trouble." Because the nurse is willing to do anything for a patient she not only wants to give her good care, but keep her patient happy, and food as well as health in most cases means a great deal toward happiness. One nurse said, "I like to fix the trays I serve with just a little personal touch, I know what my patient wants." It isn't really much, but the dietitian said, "That is ridiculous—you just baby your patient." I know that the nurse who served these good trays may have taken food in the kitchens from other patients and the students' trays often looked very meager. If the head nurse was not there constantly, she left the outside lettuce leaves for the other patients and she never thought of putting it back in the cooler so it would be crisp for others.

Jessie Conrad said, "Good cooking is a moral agent." By good cooking I mean the conscientious preparation of the simple food of every day life, not the more or less skillful concoction of idle feast and rare dishes. Conscientious cookery is an enemy of gluttony. The trained delicacy of the palate, like a cultivated delicacy of sentiment, stands in the way of unseemly excesses. The decency of our life is for a great part a matter of good taste, of correct appreciation of what is fine in simplicity. The ultimate influence of conscientious cooking by rendering easy the process of digestion, promotes the serenity of mind, the graciousness of thought, and that indulgent view of our neighbors' failings which is the only genuine form of optimism.

Now, may I say a word about the food that the nurses themselves eat. I wonder sometimes how the dietitians really enjoy the food they serve. All hospitals, I think, buy the best food it is possible to buy. The chef cooks the meat until you would never recognize it, then adds all kinds of peppers or dressing to change the taste. Vegetables are cooked to pieces or half raw. I sometimes wonder if creamed dishes are served because they go father in a serving, and last, but not least, why serve potatoes, hominy and pudding on one menu?

Most nurses, whether on private duty, institution or public health work, are dependent upon their basic training course for their knowledge of foods and nutrition. The student nurse is dependent upon the dietitian for one of the most vital parts of her professional education. It is unfortunate that the latter is often handicapped in teaching the student nurse because of lack of time for personal contact with the patient. The nurse and dietitian are expected to be informed on matters pertaining to diet for normal individuals in all walks of life.

Here are two sides of the question, "Cooperation Between Nurses and Dietitians," as presented at the recent meeting of the Colorado Hospital Association. The points mentioned are deserving of consideration of every hospital executive. Incidentally, the Colorado association is to be congratulated upon presenting a subject in this way, thus bringing out many ideas and special conditions that undoubtedly would not appear if a one-sided discussion were offered.

What can be done to bring about a closer cooperation of the nursing and dietetic department? This question is important since the lack of co-operation between the dietitians and nurses in some hospitals is a distinct handicap to the service that the patients should receive. Both departments now play an important part in therapeutics, yet each is dependent upon the other in curing the sick. Unless the right food, properly chosen and well prepared, is delivered to the nurse, her other services will be of little avail to the patient. On the other hand, the dietitian is at the mercy of the nurse in the matter of serving food directly to the patient, and no matter how perfect the diet, it will be of no account unless the nurse carries out the orders of the dietitian quickly and precisely.

As I have stated, before the advent of the dietitian to the hospital and the development of the central tray service, the preparation of trays was in the hands of the nurse who had to do the best she could, with what little knowledge of dietetics she possessed, to prepare and serve the food to patients requiring special diets. Does the dietitian lose sight of the fact that the nurse is in constant contact with the patient? The dietitian should never lose sight of the fact that the nurse can help her with the so-called fussy patient. The nurse tells the dietitian the patient wants one egg and one piece of toast and she puts on the tray the eggs and toast, but not the right amount. If the dietitian could only hear the patient say to the supervisor, "I only want what I ordered and that extra piece of toast was wasted—it was too large a helping and I could not eat my breakfast." Or, perhaps the patient is overweight and knows she should diet. If her helpings are too small, so that she is unable to leave a little, and she can say, "I never ate all the food on my tray, doctor," she is unhappy and feels she has been forced to diet. An overweight patient is hard to deal with unless tactfully handled when ill because they have just as much pain as a thin person, but need more sympathy, for the nurse may show that they are hard to turn and handle. Yes, this sounds ridiculous, but it happens.

As with any system in institutional

life, there is bound to arise at times misunderstandings and friction between members of the two departments in carrying on the duties that are so closely bound together. Looking back into history, we see the causes of existing difficulties between the two departments. During the pioneer days of nursing, the nurse was forced to cover more ground than she could do, if the work was to be well done. Something had to go undone, and the serving of food was the first duty to let slip. The nurse naturally turned her immediate attention toward the dressing of wounds, administering medicine and the personal care of patients. Tray service became secondary unless a special nurse came on the case, and although the trays were perhaps served hotter, food cooked better, the food was no good, for it was re-warmed or too much fried meat was served.

But when science in her further strides, called for more and more specialized diets, with better food service, the nurse found herself facing situations with which she was unable to cope. Scientists then suggested training people for this work alone and dietitians and the profession of nutrition came into existence as an important and integral part of hospital administration.

The nurse gladly turned to what was attractive to her, but later realized that she had lost an important part of her work and adjustments had to be made by her. These changes have not been accomplished without some friction. For instance, no dietitian likes to have her trays worked over by special nurses if the food is not hot or properly served. Take it back to the one who is in command, do not talk about the dietitian and try to fix the food by re-heating, let the dietitian take the situation over and correct the mistake. Would the nurse like the dietitian to question her method of making beds?

As the scope of her work has broadened, the nurse's interest has grown away from the trays of the patient toward the medical and surgical aspect of her work, and the dietitian has taken up this work. But the dietitian must never lose sight of the fact that the patient is not part of the mechanical apparatus of the kitchen, but a human being.

Nurses and dietitians must work out the daily routine of life with one purpose in mind—service to humanity. If it were not for the patient, there would be no nurses or dietitians.

Let us see the dietitian more often in our staff meetings as she is certainly part of the teaching staff.

Dietitian's Viewpoint

By Rosella Hanfeld
Dietitian, Mercy Hosptial, Denver, Colo.

Nursing Viewpoint

THE subject of cooperation between the dietitian and nursing staff might seem to some trite. Certainly the need of such co-operation is so self-evident that it requires no comment. The welfare and lives of patients are entitled to the utmost in co-operation and co-ordination, not only between dietitians and nurses, but among doctors, interns, superintendents, dietitians, nurses and even those to whom are delegated the menial tasks in and about a hospital.

Sometimes I feel that each of us in our separate departments become so engrossed with our own small cog of the machine that we are prone to forget the machine as a whole.

Trying to look at the question from the viewpoint of the patient, the outsider—the inadequate functioning of this machine is the indictment against the modern hospital. A patient is sensitive—his mental outlook is confined to his illness and his immediate surroundings. He rarely objects to his medical attention—except for his oft-repeated query, "When is the doctor coming?"—but noises, lack of prompt attention, poor nursing care, cold or inadequately prepared food—these and myriads of other details are all important to him. In the non-observance of these details, due to lack of co-operation many hospitals are subject to criticism.

For some reason or another I cannot help but adhere to the notion that the ministration to the sick is a devotion to a cause. I am sure such a notion is the foundation upon which such characters as Pasteur, Nightingale and Eijkman are based.

If what I have said be true, then isn't "co-operation" a thing not merely to talk about, but an absolute necessity? Is it not positively essential that we always remember that our particular department is merely a cog in an intricate machine, and that the unit as a whole *must* function?

Now as to co-operation between the various departments, and later, more specifically between dietitians and nurses.

Inasmuch as this paper is intended to provoke discussion, I will make no effort to refrain from partisanship in my viewpoint. I am well aware that dietary departments merit constructive criticism, and it is always welcomed. Any criticism which I may direct toward other departments is intended purely to be constructive and for the sole purpose of the better functioning of the unit as a whole.

The staff of physicians and surgeons is the nucleus about which our hospital organization is formed. Naturally we look to the doctors for guidance and inspiration. And here let me make a suggestion to them in the matter of co-operation. Are they not inclined, as a result of their all-absorbed attention to the surgical and medical aspects of a patient's life, to become careless and intolerant of other necessary details of hospitalization. Adequate, well-temperatured, properly served food, and earnest, unselfish care are just as essential to the welfare and the convalescence of the patient as is medical attention. One is as necessary as the other, and excellence in one is as desirable as excellence in another. The doctor makes his rounds and is gone. He is prone to forget that the supervisors, the nurses and the dietitians carry on 24 hours a day. It is the little things which make a patient contented or discontented. If the doctor would but remember this, the precept and example in cooperation which he could set would be of infinite value in stimulating cooperation between other departments. Perhaps careful consideration of the problems of hospital management and supervision would make him more sympathetic with details, which mean so much in a patient's life.

I wonder if a doctor ever stopped to realize that meal-time in a hospital is the same as meal-time at home. He drops in during tray service; supervisor and nurses are taken from their work, the served trays stand in the diet kitchen, hot food gets cold and cold food gets warm. When the doctor is gone and the food finally arrives, it is not palatable. A small detail. Yes, and used merely as an example of the necessity of cooperation between doctors and hospital management.

Now let us consider cooperation between dietitians and nurses.

A dietitian has a permanent position as compared with the transient student nurse or the one on special duty for a day. She naturally feels herself a part of the institution with which she is associated and is bound by loyalty to it. She is a definite part in the growth and development of the hospital and its success is therefore vital to her. Loyalty among department heads reflects itself in all workers, and this indeed is of infinite value to any institution. It is a thing that cannot be over-estimated.

An efficient dietitian is not a faddist but uses common sense and skill in applying her scientific knowledge.

She does not direct her patients to "go starch" or "go protein," or lay down laws of "do's" or "don'ts" in food combinations. To her it is not all-important that celery be served with every course until the dessert at a protein meal. Nor is she advocating that starches and sugars combine with each other and with all fats, salad greens and vegetables, except "cooked tomatoes." Such dietetic extremes she leaves to faddists. The special diets are rapidly becoming an abomination of the past so far as patients are concerned.

The time is not far distant when with only a few exceptions a special diet will be merely a variation of the basic normal diet. In the hospital, as well as in the home, the patient is a part of the family, living as nearly as possible a normal life. It should be the aim of the hospital to duplicate his home surroundings.

To keep the institutional machine running smoothly, each department must try to remove the obstacles that are constantly causing friction and interfering with its perfect motion.

The difficulties that daily confront the dietitian and the nurse are based primarily on the failure of each group to visualize and evaluate the purposes and efforts of the other. The very organization of the hospital makes it easy for each department to shift responsibility. If the dietitian could prepare, deliver and serve all the food, it would definitely fix the responsibility, but the financial demands of such a procedure render that impossible.

Furthermore, the dietitian has the education of the student nurse to consider, and the responsibility in this respect is just as great as that of the departments of surgery and medicine. Unfortunately some training schools seem to have neglected the proper training. As a result, the student nurse is not encouraged to accept the right kind of diet responsibility during her service as diet nurse. The students' mental attitude toward her work is of great importance; unless there is a profound conviction of the worthiness of the task and an earnestness of purpose, nothing can be accomplished. Destructive criticism of a supervisor or a discontented attitude of a nurse should not be tolerated at any time.

The co-workers of the dietary department may be jealous or suspicious because of a lack of understanding of the relation of the dietitian to other departments. The supervisor and nurse sometimes feel that the dietitian gains too much favor with a patient after a visit to the room. The welcome often extended to the dietitian is like a smallpox sign on the front door panel. The introduction to the patient is frequently an embarrassing one. They often object to the dietitian's contact with the patient and frequently withhold valuable information and help to her in adapting the diet to the patient. Naturally, then, any difficulties about the trays or delays in service are willingly cast upon the dietary department, where they often rightfully do not belong. Fortunately this type of annoyance is passing rapidly.

The doctor has done much to correct such false impressions and lack of understanding on the part of supervisor nurses. The doctor writes an order for routine diet and he likes to feel that the dietitian can make the adjustments indicated in each particular case. He appreciates the dietitian's personal contact with the patient to get the patient's viewpoint. Friendly discourse between dietitian and nurses will help to allay any fears of favoritism and to keep out the enemy, jealousy, which caused so much disorder.

Cooperation between the two prominent departments leads up to an economic factor. It helps in the reduction of waste. The supervisor is in a position to observe certain foodstuffs being declined by the patient, and should note such a change in his menu before the tray is served, and not after it has been delivered from the kitchen. Careful check on nourishment and refrigerator supplies prevent an excess of any food, thereby eliminating spoilage. An accurate check on distribution of supplies prevents duplicate orders. Many a request for special catering may be eliminated by the diplomacy on the part of the supervisor when an order for special food is not necessary. This saves the hospital money, time and labor.

To the diet nurse falls the clerical duty of new admissions, transfers and discontinued trays, as well as changes in diet orders.

Each patient deserves individual attention. The greatest number of food complaints come from what may seem to many, trivial things, things which every observant person should expect, those things which often require no expert knowledge. Attention should be given to the kind of bread desired, the kind of beverage, whether the patient cares for large or small portions and the like. Obviously the patient is annoyed with a general tray the day following teeth extraction. The result is a displeased patient for no good reason. Why can't the dietitian depend upon the nurse for these details?

In case a patient is due for operation, discharge or X-ray, the diet laboratory should be notified immediately. Otherwise the time involved in the careful calculation and preparation of the special tray is lost. Too often this information is neglected by the nurse, and the tray remains unserved—a loss of efficiency and of food to the hospital. There is no more irritating experience than to carefully plan and supervise a special tray, and then to discover that there is no patient to appreciate it.

When the special diet patient is planning to leave the hospital, the therapeutic dietitian should be notified. She needs to give diet instruction and to prepare the patient to carry on his hospital diets at home.

Of all the departments in a hospital discussed most frequently by patient, ex-patient, future patient, his friends, relatives and in-laws, the dietary and nursing departments head the list. A patient may live with a minimum of proper food and a minimum of care, but he will rue the day that he ever has to return to a hospital supplying those minimums. Through close cooperation and constructive effort, it is perfectly possible and practical to supply him with a maximum of those things which mean so much to him. Let each patient leave the hospital, talking about excellent food and excellent care, instead of harping perpetually about his "operation." Then the dietary and nursing departments will steal the doctors' "thunder."

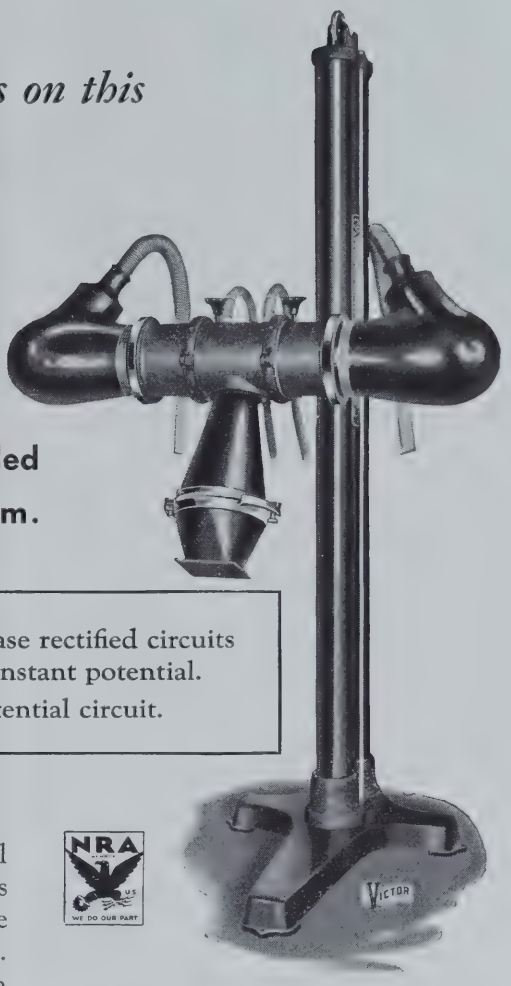
Human ingenuity has succeeded, in most instances, in providing inventions for the performance of mechanical labors. To date, no conveyance has been developed, which will take the place of cooperation between dietitian and nurse in getting adequate, well-balanced, attractive food to the patient—hot when it should be hot, cold when it should be cold. The patient should be fully prepared for the meal when the meal is ready—the nurse should be on the floor to deliver the tray. If the dietary department is prompt in preparing the meal, the nurse should be prompt in serving it to the patient. Clock-work precision and complete cooperation are vital all along the line between the time food is prepared and the time it is served, if we are to have satisfied patients.

True co-operation and a greater blending of the two departments are desirable. With sincerity, devotion to purpose, sympathy with each other's problems, and above all, the sublimation of personal interests to those of the patient, we should go far in making our machine function smoothly and efficiently.

Note Capacity Ratings on this

New Shock-Proof Deep Therapy Unit

with XPT Coolidge Tube Immersed in Oil and Cooled by Oil Pressure System.



200 kv. p., 25 ma. } on single phase rectified circuits
220 kv. p., 20 ma. } other than constant potential.
200 kv. p., 18 ma. on constant potential circuit.

IT'S a long stride from the conventional type of high voltage x-ray apparatus and this, reaching a new threshold in the design of equipment for deep therapy.

The Coolidge tube is not operated in air as heretofore, but is immersed in oil and sealed within its grounded container. This, together with the use of insulated cables from the high tension transformer, makes the equipment 100% electrically safe and shock proof, and insures more stable operating conditions at considerably increased energy ratings, independent of atmospheric conditions.

Maximum protection against tube failure is realized through oil insulation, which also contributes to a compactness that is surprising when the high capacity ratings are considered. The same oil is used, under a pressure system, to both cool the anode and immerse the tube. The use of insulating materials especially adapted to the requirements, minimizes any possibility of deterioration in the high tension cables.

And so again the principle of operating the x-ray tube in oil establishes a new high mark in efficiency of x-ray equipment.

In your consideration of facilities for radiation therapy, do not overlook the very definite advantages you will realize through using this apparatus. Full particulars on request.

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A GRAIN *of* POPCORN

(The facts on which this story is based were furnished by Mr. Robert Jolly, President-Elect A.H.A.)

SILHOUETTED against a late afternoon sun the little group trudged its way up the gravelled path to the door of the hospital. Six of them. Father, mother, and four children. Wearily the man held up a wheezing, whimpering infant to the Superintendent and begged him to do something. Two days before a grain of popcorn had lodged in the child's throat.

Backwoods folks they were, poorly clad, uneducated, but a simple child-like faith—unusual in these days—had carried them a hundred and twenty miles across country to a hospital.

Deft handling of modern instruments removed the offending grain and the little baby was soon tucked into a crib under a nurse's care. The rest of the family also were cared for at the hospital until the next evening when the baby was restored to its joyful mother.

Later, that night, a train rushing northward carried a happy family. In silence the man watched the woman as she held her sleeping baby close. Suddenly a tear rolled down his weather beaten cheek. A soil-stained hand stretched out and patted his wife's knee. "Think of it, Ma! Them not chargin' us a penny and then payin' our fare home, into the bargain. It don't sound possible. I didn't know there was a place in the world like that!"

● *In an age unbalanced, such things we need to bring us back again to faith in each other and society as a whole.*

THE RECORD DEPARTMENT

NORTHERN CALIFORNIA ACTIVE

The Record Librarians Association of Northern California opened its fall meeting at Highland Hospital, Oakland, when the following officers were elected:

President, Jeanette Richmond, record librarian, Fairmont Hospital, San Leandro, re-elected.

Vice president, Mrs. Grace Finchley, record librarian, St. Francis Hospital, San Francisco.

Secretary-treasurer, Marjorie Larson, record librarian, Ross General Hospital, Ross, Marin County.

Corresponding secretary, Nella B. Harris, record librarian, Highland Hospital, Oakland.

Mrs. Finchley was asked to accept the chairmanship of the program committee for the coming year. Following the business meeting a delightful lunch was served in the dining room of Highland Hospital, Miss Harris acting as hostess.

The second meeting of the fall was held at Ross General Hospital, with Miss Larson as hostess. There were 16 present, representing 12 hospitals and two superintendents. Honored guests were Mabel Wilson, superintendent, Community Hospital, San Mateo, and Ena Bundt, superintendent, Ross General Hospital.

While waiting for some of the members to arrive we were shown through the hospital, which is a delightful little place nestled at the foot of Marin County's hills revealing an ideal setting surrounded by beautifully kept grounds, giving one the impression of freedom and quiet.

After a delightful turkey dinner served by the hospital, the president, Miss Richmond and Alice Kirkland gave an interesting account of the Chicago convention, bringing out the important points on the various papers presented.

An invitation from the Western Hospital Association asking us to be the hostesses at a meeting of record librarians with that Association at their annual convention in Sacramento next April was accepted. Accordingly an invitation was extended to the Association of Record Librarians of Southern California to join with us in a three-day session, and it was also suggested to extend the invitation to record librarians throughout the Western Coast.

Mary Craven, record librarian, Sutter Hospital, Sacramento, was appointed chairman of the general arrangements committee, and Esther Badger, record librarian, Woodland Clinic, Woodland, chairman of exhibits committee.

The previous meetings with the Western Hospital Association both in Oakland and Long Beach have been so successful that we are looking forward to a splendid meeting in Sacramento next April.

PHILADELPHIA RECORD LIBRARIANS

The October meeting of Philadelphia record librarians was held at the Episcopal Hospital. The president called the meeting to order. Dr. Richard H. Meade, Jr., associate surgeon of the hospital, gave a most instructive talk on "Diseases of the Chest," using the outline in the classified nomenclature of disease, and explaining by diagram the structural changes taking place in the chest. The roll showed 17 hospitals represented

Gertrude Hanauer of the Graduate Hospital spoke about the national convention of record librarians in Chicago. A list of questions discussed at the convention which was of much interest to the librarians.

Dorothy Snyder, of the Fitzgerald Mercy Hospital of Darby, Pa., applied for membership.

The November meeting with the File Executives' Association of Philadelphia was discussed.

Refreshments were served, after which we visited parts of the new hospital building and the record room.—Nellie J. Keller.

HOUSEKEEPERS' ASSOCIATION

Cleveland Chapter

The Cleveland Chapter of National Executive Housekeepers Association has as a slogan "One new member for each monthly meeting." Miss R. A. Lance, president, reported that this was accomplished at the October and November meetings and that Dorothy Urban, of Hotel Cleveland, was to be the new member at the December meeting—a Christmas party at Hotel Hollenden.

Chicago Chapter

The November meeting of the Chicago Chapter, National Executive Housekeepers Association was held at the Women's City Club. A thrift talk was made by S. E. Brown of the Fidelity Investment Association, Wheeling, W. Va. Miss Kohli, formerly of the Sherman Hotel, made a few remarks on the advantages and comfort resulting from saving money, based on her personal experience.

Obligations of Hospitals to Graduate Nurses

By Sister M. Stella
Wichita Hospital, Wichita, Kan.

WHAT is the obligation of the hospital to the graduate nurse?

Many of this group, since they have been graduated, have not had the advantage of supervision and have failed to maintain the standards of conduct and technique inculcated by their school. But the endeavors which they did put forth, and the diligence and perseverance practiced by them, in preparing themselves for their profession, indicate an obligation.

The reputation of the hospital and the good of the nursing profession, as well as the benefit that may accrue to the nurse herself, demand that we fulfill the obligation of guidance.

The eye sees only that which is in its field of vision, and the impressions of her shortcomings and laxity are seldom made upon the nurse herself. But if we of the hospital group do our part, very effective guidance may be brought about to help the graduate nurse employed in our hospital, regardless of the position she occupies.

This guidance may take the form of conferences with the staff of graduate nurse supervisors and head nurses which may touch upon ethical problems, technique, management, economy and consequently efficiency.

Again, by example the graduate may be guided, if the person in charge of nursing service is alert and interested in the latest developments in medicine and surgery, and the technique necessary to carry out these procedures.

The atmosphere of the hospital should help the graduate to keep the standard of calm, efficiency service to patients and their visitors in evidence.

Some member of the hospital personnel should be interested in the graduate group and ready to advise and direct any nurse who comes to her with a problem. The approachability of the adviser and the aid given to the individual nurse are important factors in the discharge of this obligation of guidance.

Facilitation for Advancement

The multiplicity of specializations in the nursing field today need to be met and acquired, if possible, as one year's advances in technique are often surprising.

Progress in science, medicine and surgery are demanding more specialized types of nursing procedures which become a part of a nurse's routine, whether on private duty, as a supervisor, or general duty nurse in a hospital. The nurse should be encouraged to attend lectures and institutes for nurses whenever possible to meet these demands.

The library of the nursing school should also be placed at the disposal of the graduate, and every help possible afforded her for research.

Post-graduate education should be encouraged, particularly at this time, when the time spent in study will not mean such a loss financially as might be the case

From a paper before 1933 Kansas Hospital Association convention.

when nurses were more in demand for private duty.

Short courses at a university, a six weeks' summer session, would be an advantage when a short leave-of-absence is available.

By encouragement facilities for advancement should be presented to the graduate as a part of our obligation.

Because the desire of the hospital to improve the technical knowledge of those who cared for the sick under its roof was the beginning of nursing in general, some folks are of the opinion that hospitals should employ all the nurses who are unemployed.

The need for nurses in various capacities makes it possible with proper distribution for more nurses to find employment.

However, the hospital that makes use of as many graduate nurses as possible in its staff work and calls the nurse most efficient and best qualified for the particular case on private duty, is not under obligation to maintain a placement bureau with its other responsibilities, nor to employ every nurse whose only recommendation, perhaps, is that she is unemployed. This lack of initiative in finding some place where her nursing qualifications may be useful is probably one of the reasons her nursing is not in demand.

Organization

The lack of permanence of the personnel of many of our organizations make activities for graduate groups rather unstable. If the hospital, a permanent institution, be used as a hub of the graduate organization activities, much benefit may accrue from it.

Alumnae associations, guilds, study clubs, social organizations all may help the graduate nurse to form many delightful contacts which will aid her in her professional life.

In conclusion, allow me to summarize briefly the obligation of the hospital to the graduate nurse as I see it:

There is first that of obliging her to keep at her best in her professional capacity and of helping her to improve her knowledge.

Next, of assisting her by gentle guidance to make the ethical decisions so important in a nurse's career.

Then, of aiding the nurse in her education that there may be more demand for her services and thus relieve unemployment.

Lastly, by organizations radiating from the hospital for the social and professional benefit of the nurse, to enrich her life so that it may reflect the lesson of One "Who went about doing good."

THE HOSPITAL CALENDAR

New England Hospital Association, Boston, February 16-17.

Ohio Hospital Association, Cincinnati, April, 1934.

American Hospital Association, Philadelphia, 1934.

Protestant Hospital Association, Philadelphia, 1934.

Midwest Hospital Association, Tulsa, Okla., May.

Illinois, Indiana, Wisconsin Associations, Chicago, May 2, 3, 4.

National Methodist Association of Hospitals, Homes and Deaconess Work, Congress Hotel, Chicago, Feb. 13-14.

Hospital Association of Pennsylvania, Pittsburgh, April 10-12.

North Carolina Hospital Association, Charlotte, April.

People and Products

By Kenneth C. Crain.

J. H. White, vice president of the Bard-Parker Co., who introduced removable knife and scissors blades to the surgical field, has been spending much of his time lately in Washington and on the way there and back, in connection with the discussions about the NRA code which will govern the manufacturers of surgical instruments. The matter has been brought very close to adjustment, with the views of leading hospital and other organizations interested given full attention, and the object of protecting buyers of surgical instruments kept always in mind. Mr. White's part in this intricate and difficult job has been an important one.

Ed. Kornhauser, for several years one of the most popular and widely known salesmen calling on the hospital field, in his work with the Doehler Furniture Co., New York, recently became the proud father of a fine boy. It is reported that mother, son and father are doing well, and Mr. Kornhauser has been in an exceptionally happy mood in consequence.

Macfarlane Wetmore, advertising manager of the Onondaga Pottery Co., has demonstrated fitness for a successful career in interior decorating or something of that sort should he ever leave the advertising and publicity end of the table china business. The beautiful displays of his company's wares at the various hospital and other meetings have been warmly praised for several years, and have shown the possibilities of table decoration through the use of properly selected china and accessories in striking fashion.

Sherman Sexton, president of John Sexton & Co., the Chicago house specializing in food service to the institutional field, has for several years been compelled to spend a great deal of time in New York, the company's extensive office and warehouse branch in Brooklyn, serving the entire Eastern section of the country, being largely responsible for this. Mr. Sexton finds his New York visits no hardship, however, as he has numerous friends in the metropolis, and his quarters at the Biltmore and the Pembroke Club provide every social and personal comfort. He was last in New York during the recent annual Hotel Show.

W. J. Calnan, who looks after the several industries using Monel metal in hospital equipment, also handles International Nickel's interests in other lines widely different from those in the hospital field. He has had occasion in this connection to visit all of the large dam projects now under way in charge of the Federal Government, and has had some more than ordinarily interesting experiences, not ordinarily on a salesman's schedule. Mr. Calnan has a warm spot in his heart for the hospital field, where Monel metal has been strongly established for a number of years.

H. v. H. Proskey, formerly secretary and director of the Frank Seaman agency, and later vice president in charge of the United States Advertising Corporation, was recently appointed director of sales for Lehn & Fink, Inc. Mr. Proskey is especially interested in the hospital sales of "Lysol," the company's widely known and used disinfectant, and has some interesting plans for this product in the institutional field.

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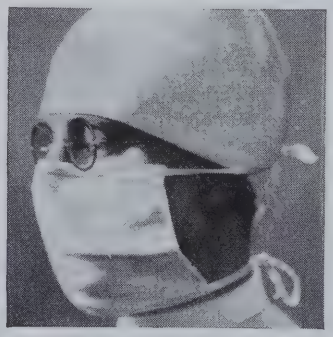

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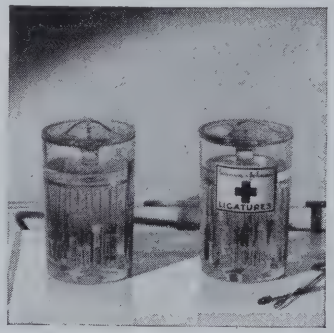

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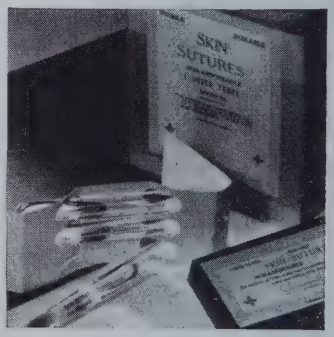

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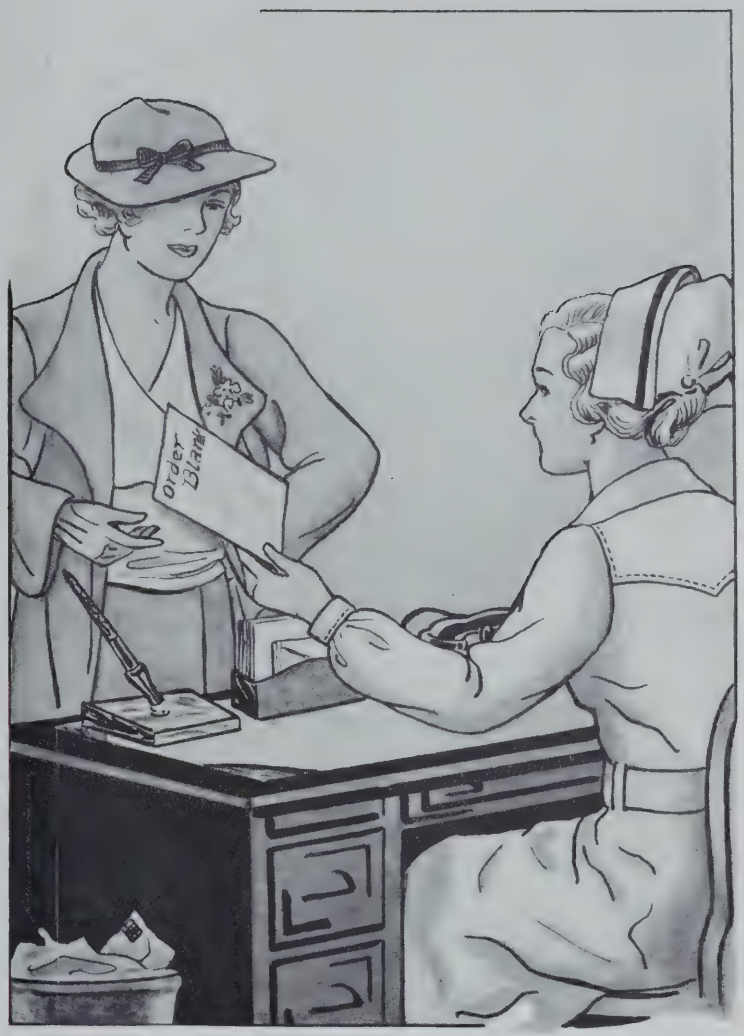

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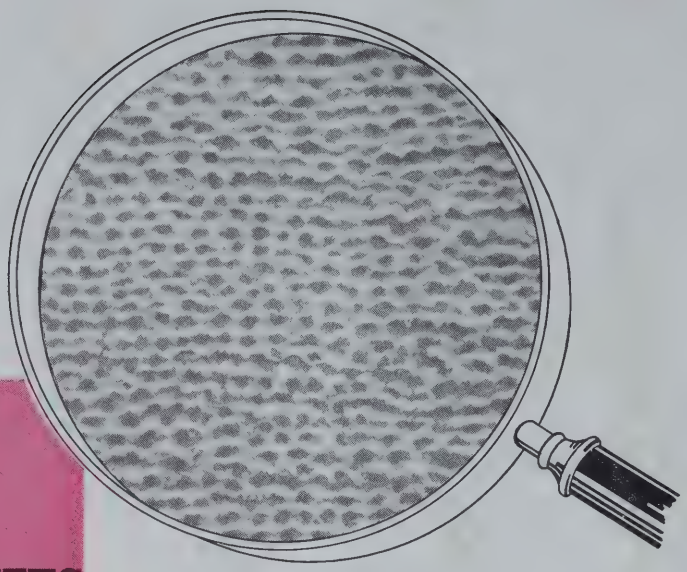

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6
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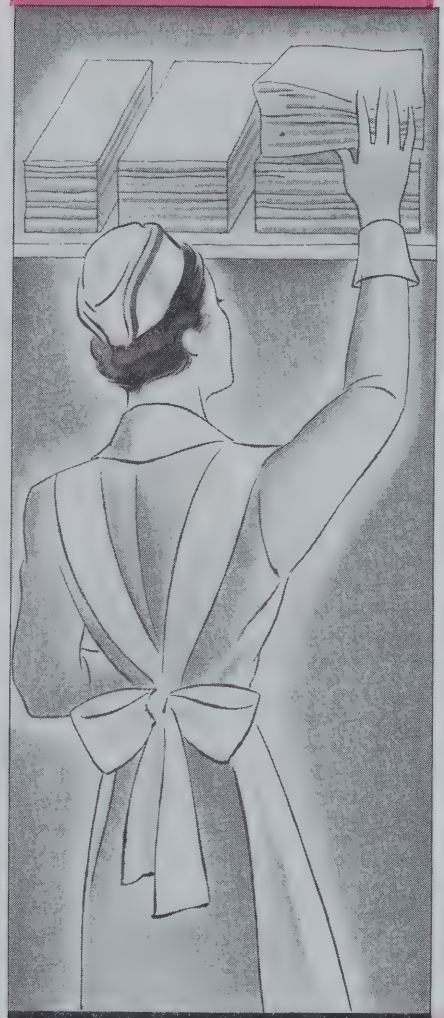

FOR EVERY DRAINAGE NEED

Cellucotton ABSORBENT WADDING

Hospital Management

A Practical Journal of Administration

NOVEMBER 15, 1933

VOLUME XXXVI—NUMBER 5

¶ Shape Publicity, Since You Can't Evade It ¶ Mr. Jolly Answers New Series of A. C. S. Questions ¶ A. H. A. Plans on 1934 Institute ¶ What Is a Registered Laboratory Technician? ¶ Personnel for 2,000-Bed Mental Hospital ¶ 14 Precautions Against Hospital Water Pollution ¶ "Why I See Salesmen One Day a Week" ¶ More Experiences With Group Hospitalization.

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1933

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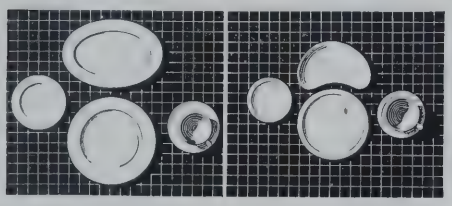
BACK in the dark ages potters angled for public favor with pigments—patterns they hoped would please. And right down the years, potters have continued to think in terms of patterns. There has been no real change in the modeling of china for literally centuries.

Our homes have changed, our clothes and our cars—but china has clung to traditional modeling—until NOW. For now, backward thinking is over. **We have dared to look ahead.**

This is our first public announcement of a new china that will stand forth as a blazing challenge to all makers of china, and users as well. Its name is ECONO-RIM, and here's how it got that name—a name to remember.

How SYRACUSE CHINA ECONO-RIM O·P·CO TRADE MARK PATENTS PENDING Saves Valuable Space on Table and Tray

The diagrams below show at a glance the almost unbelievable space economies possible thru the use of Econo-Rim. Not only will Econo-Rim cut down the necessary tray or table area as much as 34%.

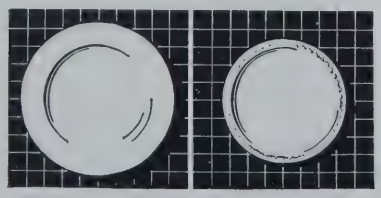


A B

Left: A typical luncheon service using a 10" plate.

Right: The same luncheon served on Econo-Rim. Luncheon A occupies an area of 456 square inches. B on Econo-Rim occupies an area of 294 square inches. The saving in space is 34%. *And the actual, usable food area of both table set-ups is approximately the same.*

But in doing so, it actually adds in some cases as much as 58% to the usable food area of an individual plate in comparing that plate with an old style plate of the same over-all diameter. The diagrams below, drawn from actual measurements prove this beyond a doubt.



Left: A conventional 10" plate. Area actually occupied by food—42.8 square inches.

Right: Econo-Rim measures 8-3/16 over all. But provides actual usable area for food of 41 square inches. Or a saving in space over the 10" plate of 36.5%.

How SYRACUSE CHINA ECONO-RIM O·P·CO TRADE MARK PATENTS PENDING Will Affect Food Profits

Every figure we have quoted was taken from an engineer's yardstick—they are indisputable facts. Remember what we said at the start about modeling having stayed the same for centuries. Over-all dimensions always the same. **And particularly the rims.**

We started with rims. First, why have rims? Secondly, did they have to be any set size? Rims serve two purposes. Something to take hold of. And a place for the pattern. Potters have stopped right there—**the rim was a place for the pattern.** Nobody seemed to realize that the rim could be made beautiful without an elaborate decoration. We cut down the rim. Introduced the pattern into the center of the plate. And by simple embossing, with just enough color to set it off, we discovered we had **the most distinguished service imaginable.**

Now to translate those savings into terms of actual profits to you who will buy this new china.

In Restaurants and Tea Rooms

If this is your business you are obliged, if successful, to constantly wrestle with the problem of additional space. You have, for example, a growing demand for "deuces." And all your tables now are probably overcrowded. What to do about it? Econo-Rim is the solution. Bring in your smaller tables. Serve the same food on just about HALF the table area now required. Get away from the present cluttered effect. And encourage larger orders because there is now plenty of room. That's what Econo-Rim does for you—and it's an easy matter to see how that will affect your profits.

Counter Service, Bars, Etc.

Again, Econo-Rim fills here a long-felt need. Sandwiches stay on the plate. Don't spread over the edge. And the busier the counter—the more Econo-Rim's space-saving features are appreciated. Every customer is treated as an individual—with his own food in front of him where it belongs.

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Econo-Rim is "made-to-order" for cafeteria use. Every tray holds more dishes. Keeps the customer adding to his order, because no tray ever looks full. Less chance for mishaps in carrying, too. Each individual plate is easier to handle—this is true in the case of customers as well as the help.

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Is there ever enough room on any patient's tray? There will be with Econo-Rim service. For balky appetites there is nothing quite so bad as a tray that looks overloaded. And nothing quite so sure to rouse the appetite as a tray that looks like "just enough and no more." We expect a lot of hospital orders, for Econo-Rim is what they have been looking for. Up to now they have never had it.

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1. Econo-Rim brings to any user an actual dollar-and-cents profit that can be quickly and accurately measured. 2. Econo-Rim will please every customer—will actually increase the size of the order. 3. Econo-Rim is easier to handle than any present china. Its breakage will be less. Its replacement cost lower in proportion.

Send TODAY for a descriptive folder which will explain more fully just exactly how Econo-Rim will fit into your own business—how it will save space—add to the size of a customer's order—MAKE YOU A HANDSOME AND IMMEDIATE PROFIT. The coupon below brings the folder to you—Free.

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HOSPITAL MANAGEMENT

A Practical Journal of Administration

CONTENTS FOR NOVEMBER

EVERY-MONTH FEATURES

BUYERS' GUIDE PAGE 4; INDEX TO ADVERTISERS PAGE 7

VOLUME XXXVI, NUMBER 5 NOVEMBER 15, 1933

HOSPITAL MANAGEMENT, published on the fifteenth of each month at 537 South Dearborn Street, Chicago, by the Crain Publishing Company. Member Audit Bureau of Circulations, Member Associated Business Papers, Inc. Subscription, $2 a year. Single copies, 20 cents. Entered as second class matter May 14, 1917, at the post office, Chicago, Ill., under the act of March 3, 1879.

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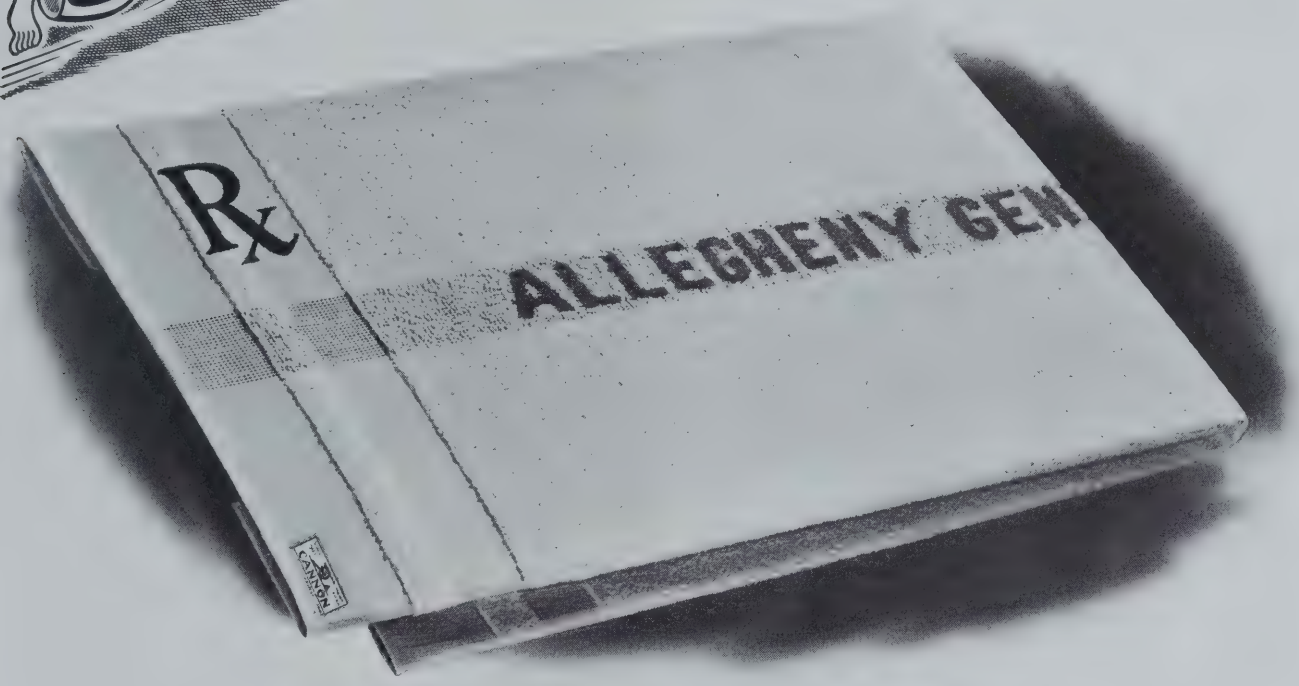
A PAINLESS CURE FOR

Expensitis



● Our specialists in towel pathology have definitely shown that no excisions need be made in the case of acute expensitis in your linen room. A mild therapy of Cannon towels generally accomplishes the desired results and a quick improvement is immediately noticed.

That's because Cannon towels in the first place cost less, in any grade, type, size or style. (Or can be had for the same price in better quality.) Which means a much lower investment, with no sacrifice of quality.

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Cannon Towels

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INDEX TO ADVERTISERS

Some Letters to the Editor

Central Food Service

Editor, Hospital Management: I note with interest a short article on central food service in your issue of October, which deserves some comment.

The comparison therein mentioned of the two 300-bed hospitals, one with a central food service and the other with floor pantry service, is absolutely meaningless without considerably more information than is offered, and this reference is likely to create an impression of validity which is misleading to those who are unfamiliar with the subject.

The fact is that many comparable institutions whose food services have been studied with the most scrupulous care can be offered unmistakably to prove that other types of food service than the central system are giving equal satisfaction from the standpoint of the quality and condition of the food served, as well as from the standpoint of cost. On the other hand, comparisons can be readily offered of institutions using the central food systems which have been considerably higher in cost than others using different methods, there being little discernible difference between the two in the quality of the food.

This leads me to repeat what I have suggested to the Institute Curriculum Committee, viz., that it seemed regrettable that, in the presentation of food service at the recent institute, entirely too much stress was laid on central food service, to the complete exclusion of other methods which continue to prove eminently satisfactory in a great many of the finest hospitals in this country. The truth is, that central food service, as advocated by this particular group, exists in not much more than 1 per cent of the hospitals on the American continent, and for very good reasons it is unlikely that there will be a noticeable increase in the future.

I have not the slightest objection to those hospitals which have installed expensive and highly specialized food services lauding the efficiency and economy of their particular methods, nor do I blame an architect who has made this type of food service planning a hobby for expounding its virtues upon every possible occasion, but it is manifestly unfair for prejudiced advocates to attempt to foist their ideas upon the whole hospital field as the one and only solution to the food service problem by the use of such questionable comparisons as appeared in the news item under consideration.

It would seem to be the consensus amongst leading administrators throughout the country that there are certain conditions under which a central food service is desirable and calculated to give satisfactory service at a reasonable cost, but even then this is not the only method of attaining equally good results. Under many other conditions the central service system is impractical, unsuitable, and involves certain commitments in planning, equipment, and operating procedures which are unwarranted.

Intelligent hospital planning necessitates a very careful analysis of the exact requirements of each separate project, the examination with an open mind of every theory or practice presented from any quarter, and the correlation of the resulting information into a compact, functionally efficient entity adaptable to those specific conditions. The clamor of those promoting fads should not be permitted to unduly influence such a program, whether it be directed toward the professional, the administrative, the architectural, or the service phases of the undertaking.

William H. Walsh, M. D.,
Hospital Consultant, Chicago.

■

From Mr. Bacon

[Note—Mr. Bacon was shown a copy of the above letter, for reply, if he wished, and sent the following note in response.]

Editor, Hospital Management: I have your letter enclosing copy of Doctor Walsh's letter and the clipping from your last issue pertaining to central food service and I note you wish me to comment on these.

When I began to develop central service back in 1912, my idea was to place the various departments of the hospital on central control as far as it was practicable. I was trying to find some method whereby the hospital could be operated more efficiently and more economically. However, central service never has been a hobby with me and I have never tried to foist my ideas upon the hospital field.

As I had charge of the food seminars at the American Hospital Association Institute in September, I of course was responsible for the program and I assume all blame if any mistakes were made.

Asa S. Bacon,
Superintendent, Presbyterian Hospital, Chicago, Ill.

■

Too Many Flowers

Editor, Hospital Management: The Evangelical Deaconess Hospital, Freeport, Ill., is anxious to institute some plan by which patients will not have an oversupply of flowers in their rooms. It has been suggested that posters be placed in the lobby and also the public be informed through the daily newspapers that only a few flowers will be allowed for each patient, and that if friends want to express their hopes for recovery or friendship and appreciation, that they deposit a comparative sum in the hospital office on the patient's account, the hospital then furnish suitable cards with which to inform the patient.

Is there anything of this kind in practice in any hospital? Could you send me literature? I am especially interested in securing posters and the proper card.

Millie E. Ploeger,
Evangelical Deaconess Hospital, Freeport, Ill.

■

Exchanging Ideas

Editor, Hospital Management: The clock poster referred to in an article on hospital publicity in the October number of "Management" is a fine idea and I think I'll "swipe" it.

Enclosed is a card that we have been using in various ways since July. We sent it to all members of the church who back our hospital whenever we write them. We have sent a little package to these churches where they were distributed at the end of the morning service. We have mailed them to Board members. Perhaps someone would like the idea. I myself lifted it from a folder that was used in much the same way as I am using this, by a hospital in Houston, Texas. (Note: This card was described in detail on page 61, October Hospital Management.

I like MacEachern's article.

In fact, the whole number is very valuable and you deserve the thanks of all of us.

Philip Vollmer, Jr.,
Superintendent, Fairview Park Hospital, Cleveland, O.

■

What Do You Say?

Editor, Hospital Management:

Would it be practical for you to have a portion of your publication, say a page or even a portion of a page, devoted to suggestions from small hospital executives? Could they be in somewhat of the form used in many women's magazines of practical suggestions, rather limited as to number of words? Either questions or suggestions could be used.

Personally I would like to know a remedy for or rather destroyer of our most annoying insects. Eternal vigilance is necessary, of course, but what is the treatment for wicker sun-parlor furniture that has become infested?

In serving family style to the personnel we have saved on milk bills by having half pints of milk served everyone instead of pitchers of "half and half," to which the first comers helped themselves and maybe the last lost out.

Ella M. Shaw,
Helena Hospital, Helena, Ark.

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—dependable because of the time-tried D&G system of manufacture wherein control begins with the raw materials and follows through to the finished product.

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The confidence which the profession places in D&G sutures is sustained by their proven dependability in actual use.

Kalmerid Catgut

EMBODIES all the essentials of the perfect suture. Being impregnated with the double iodine compound, potassium-mercuric-iodide, it exerts a bactericidal action in the suture tract and supersedes the older unstable iodized catgut. Prepared in two varieties—Non-Boilable for those desiring the maximum of suture flexibility, and Boilable for those preferring to sterilize the exterior of tubes by boiling or autoclaving. Both varieties are heat sterilized.

NON-BOILABLE VARIETY

NO.		SUTURE LENGTH
1405	PLAIN CATGUT	*approx.* 5′
1425	10-DAY CHROMIC	" 5′
1445	20-DAY CHROMIC	" 5′
1485	40-DAY CHROMIC	" 5′

BOILABLE VARIETY

1205	PLAIN CATGUT	*approx.* 5′
1225	10-DAY CHROMIC	" 5′
1245	20-DAY CHROMIC	" 5′
1285	40-DAY CHROMIC	" 5′

Sizes: 000 . . 00 . . 0 . . 1 . . 2 . . 3 . . 4
also 4-0 in non-boilable variety

Package of 12 tubes of a kind $3.00

Kal-dermic Skin Sutures

A NON-CAPILLARY, heat sterilized suture of unusual flexibility and strength. It is uniform in size, non-irritating, and of distinctive blue color. Boilable.

NO.		SUTURE LENGTH	DOZEN
550	WITHOUT NEEDLE	120″	$3.00
954	WITH ½-CURVED NEEDLE	20″	2.40

Sizes: 000 (FINE) 00 (MEDIUM) 0 (COARSE)

852	WITHOUT NEEDLE	40″	1.50

Sizes: 8-0 . . 6-0 . . 4-0 . . 000 . . 00 . . 0

In packages of 12 tubes of a kind and size

Kal-dermic Tension Sutures

IDENTICAL in all respects to Kal-dermic skin sutures but larger in size.

NO.		SUTURE LENGTH	DOZEN
555	WITHOUT NEEDLE	60″	$3.00
855	WITHOUT NEEDLE	20″	1.50

Sizes: 1 (FINE) 2 (MEDIUM) 3 (COARSE)

In packages of 12 tubes of a kind and size

Intestinal Sutures

KALMERID plain or chromic catgut with Atraumatic needles integrally affixed. For gastro-intestinal work and membranes where minimized trauma is desired.

EXCEPTIONAL STRENGTH HERE

NON-BOILABLE VARIETY

Plain Catgut:

NO.		SUTURE LENGTH	DOZEN
1501	STRAIGHT NEEDLE	28″	$3.00
1503	⅜-CIRCLE NEEDLE	28″	3.60
1504	SMALL ½-CIRCLE NEEDLE*	28″	3.60
1505	½-CIRCLE NEEDLE	28″	3.60

20-Day Chromic:

1541	STRAIGHT NEEDLE	28″	$3.00
1542	TWO STRAIGHT NEEDLES	36″	3.60
1543	⅜-CIRCLE NEEDLE	28″	3.60
1544	SMALL ½-CIRCLE NEEDLE*	28″	3.60
1545	½-CIRCLE NEEDLE	28″	3.60

BOILABLE VARIETY

Plain Catgut:

1301	STRAIGHT NEEDLE	28″	$3.00
1303	⅜-CIRCLE NEEDLE	28″	3.60
1304	SMALL ½-CIRCLE NEEDLE*	28″	3.60
1305	½-CIRCLE NEEDLE	28″	3.60

20-Day Chromic:

1341	STRAIGHT NEEDLE	28″	$3.00
1342	TWO STRAIGHT NEEDLES	36″	3.60
1343	⅜-CIRCLE NEEDLE	28″	3.60
1344	SMALL ½-CIRCLE NEEDLE*	28″	3.60
1345	½-CIRCLE NEEDLE	28″	3.60

Sizes: 00 . . 0 . . 1, except *00 . . 0 only

In packages of 12 tubes of a kind and size

Circumcision Sutures

KALMERID plain catgut threaded on a small, full-curved eyed needle, or with an Atraumatic needle integrally affixed.

NON-BOILABLE VARIETY

NO.		SUTURE LENGTH	SIZES
630	WITH EYED NEEDLE	28″	00, 0
635	WITH ATRAUMATIC NEEDLE	28″	00, 0

BOILABLE VARIETY

600	WITH EYED NEEDLE	28″	00, 0
605	WITH ATRAUMATIC NEEDLE	28″	00, 0

Package of 4 tubes $1.00; per doz. $3.00

DISCOUNTS ON QUANTITIES

DAVIS & GECK, INC. ▿ 217 DUFFIELD ST. ▿ BROOKLYN, N.Y.

D&G Sutures are obtainable from responsible dealers everywhere; or direct, postpaid

Obstetrical Sutures

KALMERID 40-day catgut threaded on a large, full-curved eyed needle, or with an Atraumatic needle integrally affixed.

NON-BOILABLE VARIETY

NO.		SUTURE LENGTH	SIZES
680	With Eyed Needle	28″	2, 3
685	With Atraumatic Needle	28″	2, 3

BOILABLE VARIETY

650	With Eyed Needle	28″	2, 3
655	With Atraumatic Needle	28″	2, 3

Package of 3 tubes $1.00; per doz. $3.60

Special Purpose Sutures

WITH Atraumatic needles integrally affixed. Selection of needles and material based on consensus of professional opinion. Suture length 18 inches. Boilable.

Plastic Sutures:

NO.	MATERIAL	SIZE	NEEDLE SHAPE	LENGTH
1651	Kal-dermic	6-0	3/8-Circle	5/8″
1655	Kal-dermic	4-0	1/2-Curved	7/8″
1658	Black Silk	4-0	1/2-Curved	7/8″

Eye Sutures:

1661	Black Silk	6-0	1/2-Circle	3/4″
1665	Black Silk	4-0	3/8-Circle	5/8″
1666	Plain Catgut	3-0	3/8-Circle*	1/2″
1667	Plain Catgut	3-0	3/8-Circle	1/2″
1668	10-Day Catgut	3-0	3/8-Circle*	5/8″
1669	10-Day Catgut	3-0	3/8-Circle	5/8″

* Double armed, suture length 12 inches

Nerve Sutures:

1670	Black Silk	6-0	Straight	3/8″

Artery Sutures:

1675	Black Silk	6-0	Straight	3/4″
1678	Black Silk	6-0	1/2-Circle	3/4″

Package of 12 tubes of a kind $3.60

Tonsil Sutures

KALMERID plain catgut with a 1¼ inch half-circle Atraumatic needle of correct diameter affixed. Suture length 28 inches.

NO.		SIZE
1605	Boilable Variety	0
1615	Non-Boilable Variety	0

Package of 12 tubes $3.60

Ribbon Gut

AN absorbable ribbon of animal intestinal tissue for nephrotomy wound closure by the Lowsley-Bishop technic. Ribbon length, 18 inches. Boilable.

NO.		WIDTH
20	Plain	5/8″

Package of 12 tubes $3.00

Short Sutures for Minor Surgery

NON-BOILABLE VARIETY

NO.		SUTURE LENGTH	SIZES
702	Plain Kalmerid Catgut	20″	00 to 3
722	20-Day Kalmerid "	20″	00 to 3
742	40-Day Kalmerid "	20″	00 to 3

BOILABLE VARIETY

802	Plain Kalmerid Catgut	20″	00 to 3
812	10-Day Kalmerid "	20″	00 to 3
822	20-Day Kalmerid "	20″	00 to 3
842	40-Day Kalmerid "	20″	00 to 3
862	Horsehair	56″	00
872	White Silkworm Gut	28″	0
882	White Twisted Silk	20″	000, 0, 2
892	Umbilical Tape	24″	1/8″ wide

Package of 12 tubes of a kind $1.50

Emergency Sutures

THREADED on half-curved eyed needles with cutting edges for skin, muscle, or tendon. Boilable.

NO.		SUTURE LENGTH	SIZES
904	Plain Kalmerid Catgut	20″	00 to 3
914	10-Day Kalmerid "	20″	00 to 3
924	20-Day Kalmerid "	20″	00 to 3
964	Horsehair	56″	00
974	White Silkworm Gut	28″	0
984	White Twisted Silk	20″	000, 0, 2

In packages of 12 tubes of a kind

Emergency Suture Assortment:

900 . . Assorted—Catgut, Silk, and Kal-dermic Skin Sutures, on half-curved needles

Package of 12 tubes $2.40

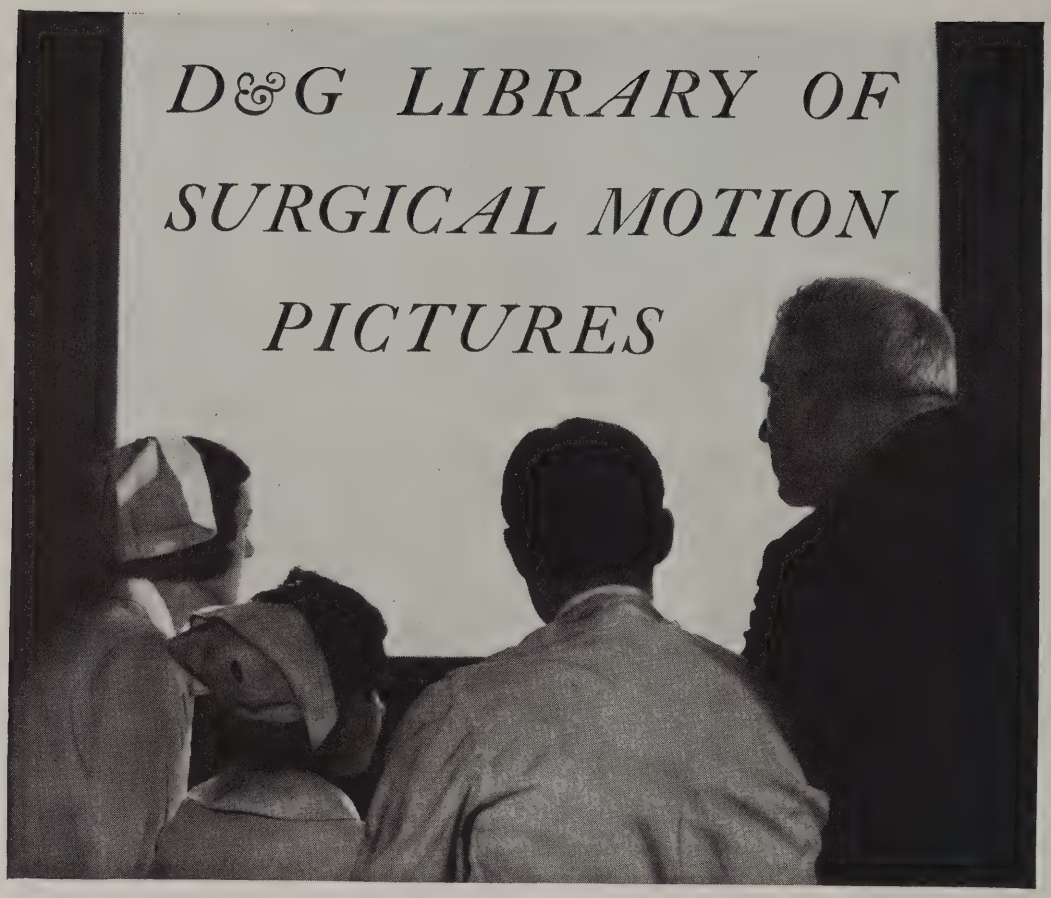
Other D&G Products

INFORMATION and prices covering silk, kangaroo tendons, horsehair, celluloid-linen, umbilical tape in jars, and Kalmerid germicidal tablets will be sent upon request.

DISCOUNTS ON QUANTITIES

DAVIS & GECK, INC. ▾ 217 DUFFIELD ST. ▾ BROOKLYN, N. Y.

Printed in U. S. A. ▾ The Private Press of Davis & Geck, Inc. ▾



ESTABLISHED in 1927, the D&G Library of Surgical Motion Pictures now covers a variety of subjects presenting the fundamentals underlying certain operative procedures and the actual technic employed in their performance. The following films are available for bookings, without charge, to medical schools, hospitals, and professional organizations. Additions are being made and will be announced from time to time.

Relation of Absorbable Sutures to Wound Healing.

Chiloplasty in An Infant of Six Weeks.

Appendectomy for Acute, Gangrenous Appendicitis—McBurney-Weir Incision.

Hernioplasty for Left Indirect Inguinal Hernia.

Hernioplasty for a Strangulated Ventral Hernia in a Woman Weighing 450 Pounds.

Orchidopexy, Hernioplasty, and Varicocelectomy

Abdominal Esophagostomy for Atresia of Esophagus in An Infant of Six Weeks.

Gastrostomy for Carcinoma of Esophagus.

Lumbar Sympathectomy for Congenital Dilatation of the Colon.

Surgical Treatment of Peptic Ulcers.

Surgical Anatomy of the Genito Urinary Tract.

Nephrotomy Wound Closure by the Ribbon Gut Method.

Perineal Prostatectomy for Benign Hypertrophy of the Prostate.

Urethroscopic Median Bar Incision (or Young's Punch Operation).

Salpingo-Oophorectomy with Appendectomy.

Montgomery-Simpson Suspension of Uterus.

Posterior Colporrhaphy for Third Degree Laceration of Perineum.

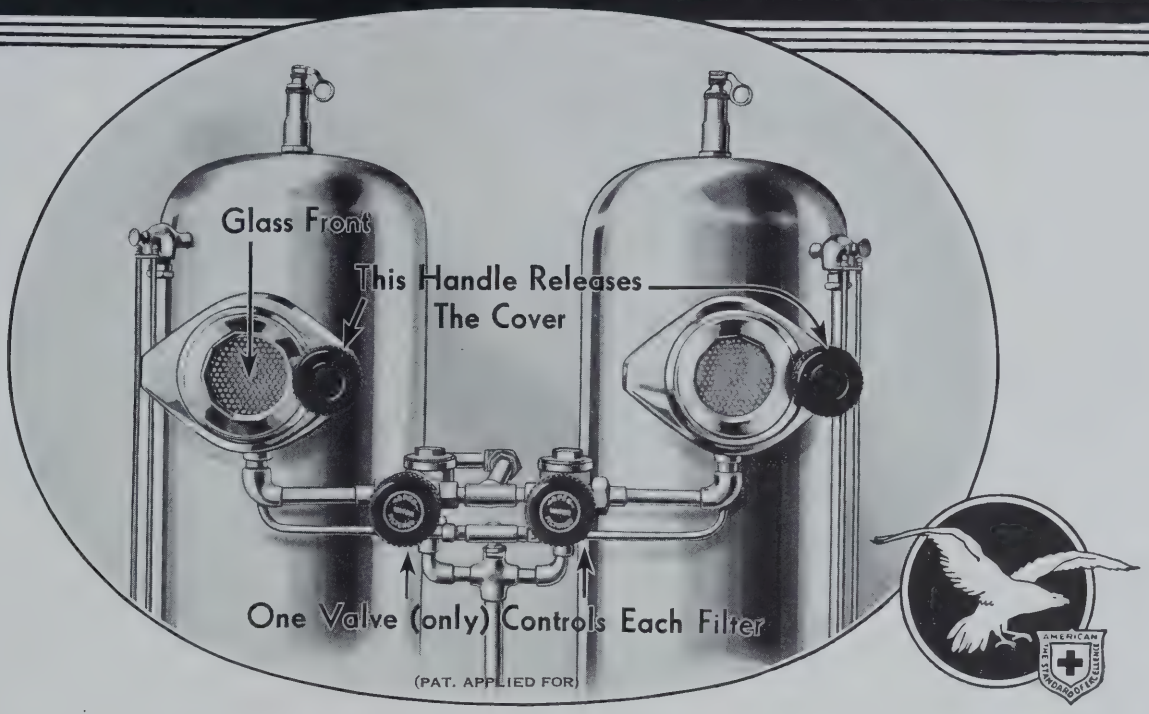
Nasal Plastic for Hump and Hook Nose.

Excision of Palmar Fascia for Dupuytren's Contracture.

Traumatic Surgery of the Extremities.

DAVIS & GECK, INC. ▾ 217 DUFFIELD ST. ▾ BROOKLYN, N.Y.

THIS SELF-STERILIZING FILTERING SYSTEM PROTECTS STERILE WATER FROM CONTAMINATION . . . . .



1 THERE IS A SEPARATE, GLASS COVERED FILTER FOR EACH RESERVOIR. This avoids that confusion of valves which so easily results in cross-infection when one filter serves two reservoirs. The front of the filter is glass covered, exposing the functioning of the filter to the operator's view.

2 THE FILTERING SYSTEM IS AUTOMATICALLY STERILIZED. When water is being sterilized, steam circulates through . . . permeates the complete filtering system . . . sterilizes it.

The usual stone filter accumulates all the foulness of incoming water for months . . . perhaps for years. No amount of scrubbing will cleanse more than the surface. The stone cannot be sterilized. Filth imbedded in its pores serves as an excellent breeding ground for bacteria . . . a dangerous source of contamination.

3 THE FILTERING ELEMENTS ARE INEXPENSIVELY RENEWABLE. The element is tough and flexible. Unlike stone filters it is not harmed by steam. When its pores become filled with (sterilized) sediment it can be replaced with a fresh element . . . easily and inexpensively.

4 INCOMING AIR IS ALSO FILTERED. Air drawn into the reservoir as water is withdrawn or in cooling . . . passes through a section of the filter which removes the air-born microbes with which all dust is laden.

This air filtering medium . . . designed for air filtering . . . replaces the dirt-collecting and inefficient air filtering cup which operators are supposed to clean and refill daily with fresh cotton.

5 THERE IS ONLY ONE VALVE. When this valve is opened, water will flow . . . visibly to the operator . . . through the filter to the reservoir. When the valve is closed, any leakage of the valve is conducted away from the reservoir into an air vented (sanitary) waste system.

6 YOU CAN APPLY THIS SAFE, SANITARY FILTERING SYSTEM TO YOUR OLD WATER STERILIZERS. The various parts as shown in the picture can be attached to any reasonably modern water sterilizers.

Gradually the details which have been most troublesome in sterilizing are being clarified by intensive study. This new filter is only one of the details typical of modern AMERICAN designs in which vast improvement has been made.

AMERICAN STERILIZER COMPANY

1204 Plum St., ERIE, PENNSYLVANIA

EASTERN SALES OFFICE: 200 Fifth Ave., New York City

CANADIAN AGENTS: Ingram & Bell, Ltd., Toronto, Montreal, Winnipeg, Calgary

A Technical Library Free to You for the Asking

Some of the best technical brains in the country, long experienced in research directed toward improving products and methods for the hospital field, have contributed to the array of literature listed below. It is carefully and often expensively and beautifully prepared for the purpose of assisting you in your work, and all you have to do is to ask for it. Indicate the numbers of such items as may interest you and we will see that they are sent to you promptly.

Anaesthetics

No. 358, 359, 360. Booklets on "Spinal Anesthesia," "Obstetrical Analgesia" and "Open Ether Anesthesia," authoritatively prepared for the profession by E. R. Squibb & Sons. 233

Cubicle Equipment

No. 337. "Privacy in the Modern Hospital" is the title of a valuable booklet on cubicle screening published by H. L. Judd Co. After outlining the problems involved in securing privacy for ward patients, the booklet works out concrete solutions for many problems. c32

General Equipment, Furnishings and Supplies

No. 342. A table showing the amount of Lysol disinfectant and water necessary to make solutions of various strength, together with a description of the correct solutions to use for various purposes in the hospital. Also a dilution chart for use in the laundry. Lehn & Fink, Inc. 532

No. 261. "Nurses' Apparel and Hospital Supplies," a 32-page catalog. Marvin-Neitzel Corp.

No. 328. "Curity Ready Made Dressings Manual," an interesting manual showing the complete line of ready made dressings, with descriptions of uses and other informative material. Lewis Mfg. Co. L31.

No. 340. A complete series of pamphlets, many of which, such as "The Mystery of Sleep," "Why the Cat Unit?" and "When Chemists Turned from Gold to Drugs," are especially useful in teaching materia medica to student nurses. Available in any quantity. Hoffman-La Roche, Inc. 432

No. 376. "Wyandotte Products for Hospitals and Institutions" explains how all cleaning in the hospital and institution can be done, and how every rule of thorough, safe and economical cleaning can be easily followed. The J. B. Ford Co., Wyandotte, Mich. 1033

No. 354. Sterilizing technique for rubber gloves, and a description of the "Anode" process of glove manufacture. Massillon Rubber Co. 1033

No. 355. "Surgical Motion Pictures," a folder describing the pictures on clinical subjects available for loan to hospitals. Davis & Geck, Inc. 233

No. 356. "Alcohol Facts," a leaflet describing the various kinds of alcohol and related chemicals used in hospital work. Rossville Commercial Alcohol Corp. 233

No. 366. "Hospital Service Book and Catalog No. 1" has just been issued by Johnson & Johnson, containing editorial and catalog material about surgical dressings, sutures, etc.

No. 367. Free of charge regularly to any hospital executive interested in radiography, "Radiography and Clinical Photography," a magazine published by Eastman Kodak Co. 633

No. 368. The "White Knight" list of quality garments for all hospital purposes, as well as linens and blankets, with prices. Issued by Will Ross, Inc.. 733

No. 364. "The All-Wool Blanket," a booklet giving details of the manufacture and care of wool blankets, bedmaking, etc. Kenwood Mills. 433

No. 370-371. A card showing color samples of blankets, and (371) a card to hang in the laundry showing just how to launder all-wool blankets. Kenwood Mills.

No. 369. "Care of All-Wool Blankets," a detailed description of the methods of storing, laundering, cleaning and otherwise caring for wool blankets so as to keep them in good condition. Published by Kenwood Mills. 733

No. 372. A handsomely-illustrated booklet describing in detail Western Electric program distribution systems for hospitals. Graybar Electric Co. 833

No. 373. An authoritative discussion of cleaning problems, "Building Cleanliness Maintenance," in attractive form. Colgate-Palmolive-Peet Co. 833

No. 374. "The Sya-Vac," a non-mechanical evacuating apparatus, just introduced by the Scialytic Corp. 1033

No. 375. "Towels and Their Story," describing manufacture, care and selection of towels for all purposes. Cannon Mills. 1033

Kitchen and Food Service Equipment

No. 378. "Cutting Refrigeration Costs," a survey of refrigeration requirements for institutions prepared by Kelvinator. 1133

No. 379. A folder on "Econo-Rim," a new design in china for the purpose of saving tray and table space. 1133

No. 363. A booklet giving quantity and individual recipes and analyses of food values of bananas. Issued by the Editorial Department of the United Fruit Co. 433

No. 365. A handsomely printed 84-page booklet of descriptive and catalog information about cooking china, teapots, etc. Hall China Co. 433

No. 349. "Practical Planning for Hospital Food Service," a 62-page booklet published by the John Van Range Co., covering every detail of kitchen and food service planning and equipment. 1032.

No. 351. "Adobe Ware," a beautifully illustrated 12-page booklet describing the newest type of china for general and tray service. Onondaga Pottery Co. 1032.

No. 276. Modern Kitchens. A 70-page booklet. International Nickel Company. C30

No. 252. "Scientific Hospital Meal Distribution." Swartzbaugh Mfg. Co., Toledo, O.

Sutures and Ligatures

No. 322. "Handbook on Ligatures and Sutures," 1931 edition. An interesting booklet on the history, preparation, handling and use of ligatures and sutures, completely revised. Johnson & Johnson.

No. 361. "Manual of Surgical Sutures and Ligatures," a 56-page description of the manufacturing processes, uses and behavior of all kinds of sutures and ligatures. Published by Davis & Geck. 333

Sterilizers

No. 234. "American Sterilizers and Disinfectors." Catalog. American Sterilizer Company, Erie, Pa.

No. 213. "Sterilizing Technique Series." Five booklets. Wilmot Castle Company.

What Members of the Editorial Board Have to Say About:

Autopsy Difficulties—Definitions of Financial Terms

What have been the principal handicaps or problems in the matter of obtaining autopsies in your hospital?

I THINK that the greatest difficulty which we meet in getting permission to do post mortem examinations is the prejudice which many people have and the ignorance of their value.—C. S. Woods, M. D.

■

OUR chief problem has been in securing the interest of the staff. We find it comparatively easy to get autopsies when the physician in charge cooperates fully. In many cases lack of enthusiasm or complete indifference has been our greatest handicap.—Clarence H. Baum.

■

The principal handicaps in the matter of obtaining autopsies in this institution are as follows:

1. The personal objection based on sentiment and the possibility that the body will be mutilated.

2. Religious objections.—Walter E. List, M. D.

■

During the year September 1, 1932, to August 31, 1933, there were 96 hospital deaths. Autopsies were done on 88½ per cent of those cases as follows:

Hospital morgue.....	55
Undertaking parlor....	30
Total	85

In addition, 110 autopsies were performed at the County Hospital, a total of 195 autopsies done during the year by pathologist with interns assisting.

We have long since overcome difficulties in securing autopsies, the medical staff doctor cooperating with the pathologist and interns in practically every case.

I am enclosing copy of autopsy report showing thoroughness and painstaking work. The original is filed with patient's chart and duplicate filed in office of pathologist.

Needless to say, from the above the Tacoma General Hospital has no difficulty in obtaining autopsies.—C. J. Cummings.

1. *What is included under "Charity Work"?*
2. *Are accounts of charity patients included in the total business of the month?*
3. *What is a "current" account?*
4. *What is a "past due" account?*
5. *What percent of current business is collected in cash?*
6. *What per cent of past due accounts is collected?*
7. *What per cent of patients pay in full on discharge?*

1. We include all cases coming into the house with the understanding that they are to be free under the heading "charity work." All work done for employes and staff members goes under the heading "courtesy work." All work done and no payment made, we cancel as "uncollectible" after two years, or when our credit manager marks them non-collectible.

2. Yes, the accounts of charity patients are included in the total business for the month. On our statements we have under the income earned a special space for deductions under which charity work, courtesy work, uncollectible and discount granted are subtracted.

3. Our current accounts are those of patients still in the hospital.

4. An account is past-due when patient leaves the hospital with a balance still due the hospital.

5. About 65 per cent of our patients pay in full when leaving the hospital, and about 10 per cent on account.

6. We average about 4½ per cent uncollectible accounts during the year.

7. We answered No. 7 in No. 5. Our cash fluctuates so that we never percent it with the current business. —H. L. Fritschel.

■

1. Charity work is that work rendered to indigents. At the time of admission or as soon as possible it is determined by investigation if the patient is indigent. Those patients who have accumulated hospital bills, which bills they are unable to pay, are not regarded as charity patients.

2. The accounts of charity patients are not included in the total business for the month, but they are included in arriving at the total volume of days' service rendered to patients.

3. A current account is an account for the private patient in the hospital. Once the patient is dismissed, the account is considered past due. However, special arrangements are made with all unable to pay their total bills upon leaving the hospital.

4. A past due account is one unpaid. We consider all hospital service to be rendered on a cash basis and such accounts as patients are unable to pay are considered past due.

5. Approximately 60 per cent of our current business is collected in cash; that is, 60 per cent of the volume of private service is collected before the patient leaves the hospital.

6. Thirty-three and six-tenths per cent of our volume of total collections of hospital service comes from that group of accounts ordinarily called "accounts receivable," which we list as patients' accounts past due.

7. Number 7 has been answered in Number 5.—E. R. Crew, M. D.

Double the quantity for the same price . . .

- The new 1-ounce hospital vial of Digalen (30 cc.) is square in shape to distinguish it from the prescription vial.
- Now hospitals in which Digalen has always been preferred to the best tincture will find it within their means to use Digalen routinely in place of the latter.
- The logical liquid digitalis preparation for following up injections made from Digalen Injectable Ampuls is the Digalen Oral Solution.

CAT UNIT DOSAGE

PRICES:

Lots of 100 vials, per vial	$ .50
Lots of 25 vials, per vial	.55
Smaller quantities, per vial	.60
Digalen Injectable, 100 ampuls	5.00

A NEW 1 oz. DIGALEN VIAL

Twice the size of the old vial at no increase in price . . . .

Each vial in an individual green carton containing a graduated minim pipette to insure accurate dosage . . .

Order from
HOSPITAL SALES DEPARTMENT, HOFFMANN-LA ROCHE, Inc., Nutley, N. J.

AD-venturing . . . . . .

"Lysol" is indeed a true economy now. Its new double-strength, secured with no increase in caustic properties—its new double-quick action in searching out and killing deadly germs—its new low price—make "Lysol" by far the most economical hospital disinfectant that can be used with absolute confidence. Page 15.

* * *

For the storage of food, hot or cold, Hall China pays its way many times over. Easiest of all ware to clean, it is free from any trace of stale food. It has no seams, cracks or crevices in which food or dirt can lodge, no nests for germs. Its glaze is leadless, free from metallic taint, free from rust. The body is vitrified, fireproof, pure white clear through, and so thoroughly non-absorbent that an ordinary cleaning removes all flavor of onions or other persistent odors. Potatoes stay white, all foods retain their fresh flavor longer, and spoilage is reduced to lowest possible terms in Hall China dishes and storage vessels. Page 16.

* * *

Leading hospitals and institutions know there is no better way to build good will among patients and insure a steady patronage than by serving wholesome, delicious desserts. That is why the slight additional price they pay to insure Gumpert quality is money well spent. Delicately flavored with fresh, ripe fruit, Gumpert's Gelatine Desserts are the choice wherever standards demand the purest and the best. Fourth cover.

* * *

Men, too, like the cool green color of Palmolive—the olive green that is Nature's own beauty trademark. Each cake of Palmolive contains olive and palm oils—the centuries-old ingredients that make skin soft, smooth. No bleaches, no artificial colors. Just the natural green of olive oil makes Palmolive green. Supply your patients with Palmolive. In spite of its prestige it costs no more than ordinary soaps. We will gladly send you, upon request, a copy of our new free booklet and prices of Palmolive in five special sizes. Your hospital's name on the wrapper with order of 1,000 cakes or more. Page 59.

* * *

When bananas are yellow with green tips, cook them as a vegetable. At the yellow ripe stage, they're excellent as fruit, but if still firm enough may also be used for cooking. When yellow flecked with brown, they're fully ripe, sugar sweet and one of the easiest of all foods to digest. It's at this stage that bananas are approved for infant feeding. Bananas should be kept at average room temperature—never in a refrigerated compartment — to develop their full, natural flavor. Page 53.

* * *

We quote from letters received from hospital superintendents (names on request): ". . . In addition to keeping the pipes clear of ice, we find that we are able to maintain desired low temperatures, and our compressor no longer has to operate 24 hours a day. The air in the boxes is sweet and clean, the food keeps better and the kitchen employes are happy. . . ." "The DeFrostaire has proven very satisfactory. It has been a distinct advantage in the proper refrigeration." DeFrostaire does help your refrigerator keep foods in better condition—more thoroughly chilled—free from off-odors. It cuts spoilage losses—reduces operating costs. Easy to install. Economical to operate. Page 53.

* * *

Modess is wrapped in gauze specially treated with a film of soft, pure, absorbent cotton, sprayed on its inner surface by an exclusive, patented J&J process. Ordinary sanitary napkins are wrapped in ordinary gauze, the surface of which is inclined to be harsh and "scratchy" on delicate skin. Modess has a downy, cushiony surface. Only Modess has this special feature. Another advantage of Modess is its special non-absorbent back. Page 64.

* * *

Better blankets by Kenwood. Better for the staff and the private rooms—better for the semi-private rooms and the wards. Better because they are built for a specific purpose. Each grade—whether it is one of the finest, softest wool, its ends bound with a luxurious satin binding or one of a sturdier utilitarian purpose—each represents a better blanket at its price. Page 6.

* * *

Average figures show that the price paid for cleaning materials is less than 5 per cent of maintenance cleaning costs. Yet the type of cleaning material used seriously affects costs by increasing or reducing labor charges. That is where Wyandotte Detergent can help you reduce cleaning costs. It cleans thoroughly and safely and is so easy to apply and to rinse away that time and labor is saved. Page 2.

* * *

Our specialists in towel pathology have definitely shown that no excisions need be made in the case of acute expensitis in your linen room. A mild therapy of Cannon towels generally accomplishes the desired results and a quick improvement is immediately noticed. That's because Cannon towels in the first place cost less, in any grade, type, size or style. (Or can be had for the same price in better quality.) Which means a much lower investment, with no sacrifice of quality. Page 5.

* * *

Curity has used and Curity is using X-ray Diffraction technique, not as a manufacturing process, but as a method of research on catgut structure, to enable improvement of the processes used in the manufacture of surgical sutures. Revealing as it does, for the first time, the cell alignment of unprocessed catgut, this X-ray research has made available to Curity scientists facts which have enabled them more intelligently and more accurately to govern catgut processing, and to definitely improve the treatment of catgut to accomplish certain results. Third Cover.

* * *

Such food service equipment will continue for years and years to be a model of cheerfulness and low cost operation. Cheerful, because of Monel Metal's bright, silver-like surfaces. And low in operating costs because Monel Metal is absolutely rust-proof, highly resistant to corrosion and easily and quickly cleaned. Its steel-like strength practically eliminates need of repairs or replacement. Furthermore, Monel Metal equipment is solid metal right through, so there is no coating to chip, crack or wear off. Year in and year out this equipment takes it on the chin—hard knocks, rough treatment—yet it goes on shining as brightly as ever. Page 51.

* * *

Delay no longer—clip the coupon and get your pair of free dermatized gloves. The new Matex dermatized gloves will give you an entirely new sense of sureness, that "silky soft" feel, slip-proof, skin texture surface improves sensitivity and *natural finger action.* We want you to test the unusual features that dermatizing alone imparts to gloves and also prove the superiority of Matex dermatized strength, toughness, non-aging, sterilization resistance qualities that have won world wide fame for Matex. Page 7.

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The Director of the Pharmaceutical Department of a leading hospital in Washington, D. C., wrote the following letter to the makers of "Lysol" not long ago:

"When I first came here as pharmacist, and for the following six years, the hospital used a cresolis compound made by one of the best pharmaceutical houses in the country. This proved satisfactory in most, *but not in all, cases.* At this time we thought that "Lysol" was the same as the cresylic preparation we were then using, having the same disadvantages, muddy solution, corrosive effect on instruments. But with your "Lysol" we got clear, transparent solutions, non-corrosive to the instruments.

"The reason why we used the other preparation so long was that it was less expensive. We received a circular explaining to us the merits of "Lysol" and we decided to give it a trial, as the *new price of "Lysol"* to hospitals was about the same as the other. "Lysol" has proved to be a far better product.

"I am not writing this letter for advertising, but I just wanted you to know that in my opinion, formed from actual experience, "Lysol" is the only disinfectant that proves satisfactory."

He did not write us for advertising! But we wrote him and asked him if we might publish his letter. He gave us permission gladly, "because I really believe in your product."

"Lysol" is indeed a true economy now. Its new double-strength, secured with no increase in caustic properties . . . its new double-quick action in searching out and killing deadly germs . . . its *new* low price . . . make "Lysol" by far the most economical hospital disinfectant that can be used with absolute confidence.

NOW REDUCED TO

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on 50-gallon contracts . . . Delivered at intervals specified in lots of 10 gallons.

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SEND THIS COUPON for information concerning our special Yearly Purchase Plan for Hospitals, and charts proving "Lysol's" effectiveness and economy.

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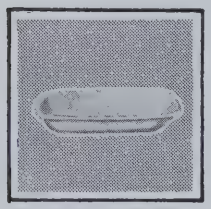

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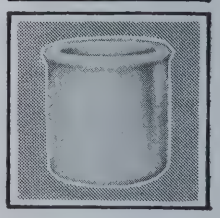

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HOSPITAL MANAGEMENT

A Practical Journal of Administration

Since We Can Not Evade Publicity, Why Not Shape It?

Newspapers, Hospital Bulletin, Convalescent Patients, Auxiliary, "Children's Alumni," National Hospital Day Win Friends for This Hospital

By ESTHER SQUIRE

Superintendent, Community Hospital, Grinnell, Ia.

IT is a well known fact that one must have knowledge of a given subject before being interested in it, therefore the community must know its hospital before it will be interested in it.

As a rule, I believe, most hospital administrators are reticent about giving out facts concerning their institution, but since we can't evade publicity of some sort, why not shape it?

Then how may knowledge concerning the hospital best be disseminated? I would like to mention several different ways. Some of these may be more closely related to small hospitals but I hope there may be some points of interest to the representatives of various sized hospitals.

Newspapers

The most common way, perhaps, that knowledge reaches the public is through the newspapers. This is more simple because journals contain such good material for publication. The editors are always anxious for news and as they become acquainted with the hospital they are interested in publishing true facts and directing the thought of the public in right channels. The facts they deal with most commonly are patients, as to name and number; descriptions of any new equipment and possible use, any unusual event at the hospital and recognition by various national organizations.

Hospital Bulletin

Along with the newspaper we think of the hospital bulletin published either monthly or perhaps quarterly. This may be an advantage over the newspaper because it can deal with hospital affairs more in detail. One particular item we have found of interest is that of donations. People give gladly and many like to see their name in print. If often serves as an incentive to others to give. Then the bulletin can be mailed to special friends and those whom you are wanting to interest especially.

I would like to mention two specific instances of how interest was aroused by our bulletin. In one number there appeared a notice of the fact that the superintendent of schools had given the hospital an oil painting of George Washington. In just a few days visitors coming to the hospital asked to see this picture. In another number appeared a description of the visit of Dr. Walker, representative of the Commonwealth Fund of New York. It was stated that he came to learn of the hospital insurance plan. Shortly after it appeared several persons mentioned having read it and began to inquire concerning the insurance plan, having decided it must be an important affair.

This plan, namely insurance, is rapidly becoming an important hospital activity and tends to arouse interest in the hospital though this is not its primary purpose. The one who sells gives out various facts concerning the hospital's work especially as to kind of services rendered, etc. The doctors also give out much information in discussing the plan with their patients. Many people call at the hospital to discuss the plan.

Convalescent Patients

One person, perhaps, who has more to do with giving out information concerning the hospital than most any other one is the ex-patient. So during convalescence it is very important that the patient be instructed properly. A satisfied patient is always immensely interested in hospital routine and life. He may like to see the laboratory, operating room, nursery and various kinds of equipment. He may even like to perform some light task. Thus he learns much of hospital life and will inevitably be telling his friends about it.

Ladies' Auxiliary

A most important organization in

From a paper before 1933 Iowa Hospital Association convention.

the life of the hospital is the ladies' auxiliary. This group is far-reaching in its work, because of the membership campaign. Then as clubs are solicited for supplies and other people are asked to help with sales and different enterprises a large number of people learn of the needs and aims of hospital and become interested. What hospital can exist without this group who are so zealous in their endeavors?

CHILDREN'S ALUMNI

Now pardon if I mention an organization in our hospital that had its beginning just a little over one year ago. I am referring to the Children's Alumni Association. The main purpose of this organization is to keep the parents of the children interested in the hospital and to have the children grow up with a knowledge of and interest in their birthplace. All children born at the hospital are eligible for membership. When the child becomes a member he is given a certificate with a picture of the hospital on it and the statement of his membership in the organization and the signatures of the doctor and hospital superintendent. Also each youngster receives a greeting each year on his birthday. The dues are fifty cents. This fund is used to defray expenses and any surplus over and above is to be used for the purchase of supplies for the obstetrical department. The ambition of the association is that when the fund becomes large enough some deserving patients can be supplied with hospital care. The association has an annual party close to Hospital Day. This year we are planning a little program to be put on by the older members. Much interest is being shown by the parents.

NATIONAL HOSPITAL DAY

This brings me to the last way available to the hospital to educate the public, which I want to mention; that is by National Hospital Day programs. This is the last, but not least. In fact, I believe this means to be the climax of all ways previously mentioned. This plan has been in existence now for twelve years. It was started by HOSPITAL MANAGEMENT and has since been taken over by The American Hospital Association. Since the beginning it has spread internationally. Each year more hospitals are carrying out the idea. So there is no doubt as to the beneficial effects of it. This event gives the public an opportunity actually to see what they may have both heard and read about. And seeing is believing. I have mentioned just a few of the ways by which the public may learn of its hospital and become interested in the hospital as newspaper, bulletin, insurance plan, ex-patient, ladies' auxiliary, Children's Alumni Association, and National Hospital Day.

A recent issue of the bulletin of American Hospital Association says: "The hospitals can no longer face existing conditions by hiding their light under a bushel; they must now educate the public in order to insure increased support and continued operation."

So I believe it is up to the hospital leaders to carry out an educational program so that the community may know its hospital and thereby become interested in it and as a result they will be anxious to support it.

14 Precautions Against Danger of Hospital Water Pollution

The New York State Department of Social Welfare recently received from Commissioner Thomas Parran, Jr., M. D., of the state department of health, some suggestions to avoid possibilities of pollution of water supply in a hospital by back siphoning and drainage from plumbing fixtures and sterilizing equipment. The division of sanitation of the department of health prepared the accompanying recommendations for hospitals and related institutions. These recommendations should be studied by every hospital in order to take advantage of this study and to avoid possibility of such pollution.

1. That all *flush valves* be provided with a combination stop and check valve or equivalent as approved, instead of only the stop valve which is normally used. This applies to toilets, urinals, flush rim sinks, etc.

2. That *valves in flush tanks* serving toilets, including the low T. N. type, be of the top inlet type and vented.

3. That water supply lines to *bidets* be provided with check or air inlet valves.

4. That all *lavatories* be provided with over-rim spouts, discharging at least one-quarter inch above the maximum water level in the fixture when flooded.

5. That *baths* with over-rim supplies should have the inlets discharge above the rim of the tub and baths which cannot have over-rim supplies be provided with an air break, air inlet valve or check valve as approved.

6. That *bed pan washers* be provided with an air break between the flush valve and the fixture.

7. That *drinking fountains* comply with the recommendations of the Committee on Plumbing of the Public Health Engineering Section of the American Public Health Association, which prevent back siphonage and protect against accidental or intentional contamination of the jet nozzle by users of the fixture.

8. That *sterilizers* be provided with air breaks and leak-protected valves on the water inlets and air breaks on the wastes. The air break on the inlet is, of course, omitted on water sterilizers as it could not be operated ahead of the Berkfield filter and back siphonage from the tanks would carry no health menace.

9. That *flush rim floor drains* be protected if possible by an air break and otherwise by an air vent or check valve. Without actual tests to determine that air breaks will operate on this fixture, their exclusive use cannot be required. It is believed that, except in rare instances, the use of this fixture can and should be avoided.

10. That *movable spray heads* as used with high tubs, autopsy tables, etc., be provided with an air inlet valve or a check valve. With proper operation, these sprays should not be allowed to become cross-connections, as the spray head should be kept, when not on use, above the fixture it serves. However, it is known that the heads are often left lying on the bottom of the fixture.

11. That *photo developing tanks* be provided with an air break on the water supply lines.

12. That all waste lines from *kitchen and pantry equipment, laundry equipment, refrigeration plants and boilers* discharge to open floor drains or be provided with an air break of the funnel type.

13. That the water supply lines to submerged inlets on *dish washers, laundry washing machinery* and similar apparatus containing polluted liquids be provided with air breaks or air vents. Submerged inlets include all inlets subject to submergence under normal operation.

14. That *laundry trays* have over-rim inlets with spouts above the rim of the trays.

A. H. A. Trustees to Hold Another Institute in 1934

Original Committee Reappointed to Arrange Plans for Next Year's Course Without Regard to Time and Place of Convention; Chicago Again to Be Scene of Lectures

By MATTHEW O. FOLEY

THE highly successful institute of hospital administration of the American Hospital Association is to be given again in 1934.

This important announcement was made at a recent meeting of the board of trustees of the American Hospital Association, at which time the committee in charge of the 1933 institute was reappointed. The members of this committee are Michael M. Davis, Ph. D., chairman; Asa S. Bacon, Presbyterian Hospital, Chicago; Dr. B. W. Caldwell, executive secretary, American Hospital Association; John C. Dinsmore, University of Chicago Clinics; Paul H. Fesler, Wesley Memorial Hospital, Chicago; Dr. M. T. MacEachern, American College of Surgeons; L. C. Vonder Heidt, West Suburban Hospital, and Dr. W. H. Walsh.

The trustees informally agreed that the next institute would be held without regard to the time or place of the 1934 national convention and that it would be held in Chicago in order that the experience of the recent institute might be utilized by the men who so successfully handled the details of the course at the University of Chicago. It also was felt by the A. H. A. trustees that the University of Chicago should be the scene of the next institute, because of its personnel and facilities.

All details in regard to the 1934 institute, however, were placed in the hands of the committee.

The announcement that the institute will be held in 1934 will be received with pleasure not only by the 200 students of the pioneer institute, but by many other hospital administrators and executives who were unable to attend the first course and who may be in a position to enroll in 1934.

The success of the institute, as reported in the last month's issue, has created a great deal of interest throughout the field. Because of this interest, HOSPITAL MANAGEMENT has sought comments from other students of the institute who did not get a chance to submit their remarks regarding their experience in time for the October issue.

In connection with the publication of the list of students and the designation of those who received certificates of completion it has been noted that in at least one instance in the list published in the October issue, one person who received such a certificate was not so designated. HOSPITAL MANAGEMENT is glad to call attention to the fact that E. R. Snyder, assistant superintendent, Wesley Memorial Hospital, Chicago, has received a certificate of completion of the institute, although this was not indicated in the published list. If similar errors or oversight occurred, HOSPITAL MANAGEMENT urges that they be called to the attention of the editor so that proper announcement may be made for the sake of the record.

The following are additional comments submitted to HOSPITAL MANAGEMENT by those who attended the institute:

I. W. J. McClain, St. Luke's Home and Hospital, Utica, N. Y.:

"It was my privilege to attend the American Hospital Association institute and I greatly appreciated the opportunity and acknowledge the benefit to myself and others to be associated with the leading hospital administrators in such an intimate way. The educational value of the institute cannot be questioned, the opportunity for free discussion of all problems of administration in the seminars is a valuable aid and the program was well balanced through the intermingling of lecture, seminar and hospital clinic so as to afford the maximum amount of benefit to the individual student.

"I personally regret that I was not able to remain through the last week of the institute. I am glad to know that there is a possibility of such an institute being held annually. I am sure that more hospital people will seek the opportunity of such refreshing associations."

"I personally found the institute very practical and helpful in every way," says N. Gertrude Sharpe, superintendent, Morton Hospital, Taunton, Mass. "It was extremely well organized for a first one, and the instructors were experts. I feel we all owe a great deal to them for their time and patience."

"I am very, very, glad I attended the institute," says Lina McMahon, Nan Travis Hospital, Jacksonville, Tex. "If circumstances permit I will attend the next, too. I wish there was some way we could show each and every one how much we appreciated what was done for us.

"My suggestions for improving the institute are:

"Have a seminar each afternoon and arrange clinics afterward. The details of clinical records, accounting, etc., would be worth more set up and discussed in a seminar.

"Students should be asked a few questions on acceptance as to problems that really interest them. Give their comments to the lecturers so that they may be touched on and answered at the seminars. Instructors are not mind readers and were often at a loss to know exactly what we wanted. Many of the questions would help them."

100 Questions and Answers

Here are the questions offered by the American College of Surgeons as timely and of greatest current interest, and the answers by the man who has conducted round tables at which these questions were discussed.

By ROBERT JOLLY
Superintendent, Memorial Hospital, Houston, Tex.

GOVERNING BODY OF HOSPITAL

1. *Should every hospital have constitution, by-laws, rules, and regulations? Who should be responsible for their preparation? What should they include?*

1. (a) By all means. The hospital can no more operate successfully without constitution and rules than a train can without orders.

(b) The governing body of the hospital, with the assistance of the staff and an attorney.

(c) In order to save space here I refer you to the report of the committee on hospital organization and management of the American Hospital Association, 1931, which will give points to be covered. Also write American Hospital Association for samples of constitutions and by-laws issued by a number of hospitals.

2. *What should be the qualifications for membership on the governing body?*

2. In order to be qualified for membership on the governing body of the hospital a man should be successful in his own business; have judgment, appreciation of the services of the hospital, a cooperative spirit, a desire to serve and financial resources.

3. *What should be the duties and responsibilities of the governing body?*

3. To elect an efficient superintendent, to support him or her in the administration, to assist in establishing public relations, to arrange loans, to defend the hospital against all comers.

4. *Should the medical staff be represented on the governing body? If not, how should proper relations between these two bodies be established?*

4. (a) The majority opinion seems to answer "no."

(b) By inviting the president of the staff or committee of the staff to meet with the governing body, or by the appointment of committee from staff and a committee from the governing body to meet together periodically.

5. *What is the proper relationship of the governing body to the (a) administrative staff; (b) personnel; (c) medical staff?*

5. (a) Relationship should be one of co-worker rather than employer, allowing freedom of action as long as successful, but giving assurance of desire to assist and advise.

(b) One of cordiality and helpfulness, but emphasizing the fact that the superintendent is the administrator and should be so recognized by the personnel and governing body.

(c) Fraternal and cooperative, recognizing in matters of science the staff must rule, but at the same time insisting that the governing body is the court of last resort since that body bears responsibility for the success of the hospital.

6. *Upon what criteria in order of importance can the governing body or board of trustees judge the efficiency of the hospital? How best can they obtain this information in a comprehensive and accurate manner?*

6. (a) (1) By the monthly report of the staff in matters scientific in the care of patients and (2) by monthly report of auditor on matters financial and (3) by the reputation of the hospital in the community.

(b) All the reports mentioned in "(a)" will provide that information. The reputation of the hospital will not be hard to ascertain; it will doubtless come unsolicited.

This is part of a series of 100 questions selected by Dr. M. T. MacEachern, American College of Surgeons, as of greatest interest during the past year. These questions form the basis of various round table discussions under the auspices of the College throughout the field. Mr. Jolly presided at the hospital conference in Chicago where these questions first were offered, and has officiated at numerous similar discussions for the College and other organizations. The remainder of the questions will appear in subsequent issues.

WOMEN'S AUXILIARY

7. *What are the advantages of the women's auxiliary in a community hospital?*

7. (1) Create interest in and friendship for the hospital. This is done by spreading correct information and answering criticisms. (2) To seek donations either of money, supplies or service. Read Margaret Rhynas' paper on page 539 in the 1932 American Hospital Association Transactions.

8. *What is the proper relationship of the women's auxiliary to the governing body?*

8. Just what the word implies and not in any sense as a co-administrator.

SUPERINTENDENT

9. *What should be the essential qualifications of the administrative officer?*

9. The qualifications are too numerous to mention. I doubt if any other administrative officer is expected to have as many qualifications as the superintendent of a hospital. I suggest some: ability to organize, harmonize, sympathize, deputize and fraternize. Must have character, education, firmness and gentleness and be able to express himself well in public. He will also need physical stamina. He must be "all things to all men."

10. *What should be the relationship of the administrative officer or superintendent to the (a) governing body; (b) personnel; (c) medical staff; (d) patient; (e) community; (f) hospital field; (g) health department and welfare organizations?*

10. The relationship of the administrative officer to (a), (b), (c), and (d) of this question should be that of the thumb to the four fingers on one's hand. The thumb must not only cooperate with each finger, but must help all the fingers to cooperate.

(a) His relationship should be informative and such as will put proper responsibility upon the members of the governing body.

(b) Relationship should be that of the coordinator. Also brotherly relationship such as will create a fam-

Here is a view of the Chicago Hospital Association booth at A Century of Progress, which was visited by many thousands of people. The American Hospital Association, Deaconess Hospital, Evansville, and several manufacturers interested in the field cooperated with the Chicago group in fitting up the booth, one feature of which was a series of slides showing original and present buildings of Chicago hospitals.

ily spirit and thereby elicit the best possible service from all.

(c) Should be liaison officer between medical staff and governing body. Should maintain a friendly relationship with medical staff and be particularly considerate of this group of individualistic personalities.

(d) Relationship of host to the patient upon whom all of the efforts of the institution are focused in an endeavor to restore to normal health as quickly as possible.

(e) An informant of the problems of the hospital and also that of one whose greatest interest is to be of help to the community. Here again I use the word liaison officer between the community and the hospital.

(f) A contributor in every possible manner and at the same time a seeker after all the wisdom that the field offers.

(g) A cooperant in every effort put forth for the welfare of the community, donating time, money and talent.

11. *How best can the superintendent keep abreast with the advances in hospital administration?*

11. By reading all the literature possible, by attendance at local, state and national hospital meetings and by contacting as many hospital people as possible. As soon as I became a hospital superintendent I began to inquire as to dates and places of meetings. I attended the American Hospital Association the first year. I noticed the first day that a man named MacEachern was called upon often to give his experience and judgment concerning difficult problems. I saw him next morning in basement of hotel getting a shine. I introduced myself and told him he seemed to know things and I wanted to know him. The attendance at any hospital meeting is a good investment.

HOSPITAL PERSONNEL

12. *What are the basic qualifications to be considered when selecting the personnel?*

12. Honesty, education, personal appearance, previous experiences and cooperative spirit.

13. *What should be the authority and responsibility of heads of departments in the organization?*

13. The administrator should fix the limits of authority and responsibility, then give freedom to get desired results in their own manner in using their own methods. Of course, the administrator will reserve the right of conferring and advising. The department head will be responsible to the administrator alone.

14. *How best should non-resident personnel be compensated: (a) salary and meals; (b) salary, meals, and hospital care when ill; (c) salary, and pay for meals and hospital care?*

14. Non-resident personnel should be compensated with salary and meals. In many instances they will somehow find something to eat in the hospital so it is better to make the meals part of compensation and thereby reduce the outlay of cash to be spent on salaries.

In Memorial Hospital, Houston, we deduct $1 per month from salary of white personnel and 75 cents per month from salary of negro personnel which takes care of group hospitalization for them.

REPRINTS FROM REPORT

Cooper Hospital, Camden, N. J., of which Huldah Randall is superintendent, and L. A. Ayer, comptroller, has made good use of some of the illustrations and charts from its annual report by reprinting these as separate leaflets and enclosing them in an attractive folder.

Canadian Hospital Council Holds Second Biennial Meeting

By G. HARVEY AGNEW, M. D.
Secretary, Canadian Hospital Council, Toronto, Ont.

THE second biennial convention of the Canadian Hospital Council at Winnipeg, Manitoba, was an unqualified success. It paved the way for many cooperative endeavors between the provinces and amply justified the formation of this body. The Council is not an association in the usual sense, but is a federation of the twelve different hospital associations in Canada, the federal government, the various provincial governments and the Canadian Medical Association. Delegates from these bodies meet every two years to consider hospital problems of virtual interest, to endeavor to coordinate hospital activities, to formulate and develop policies and standards bearing on hospital development in the future and to consider hospital legislation.

The discussions were based largely on a series of excellent studies which have been prepared in the two year interval since the organization meeting. Papers were not featured, the entire three days being devoted to informal general discussions. In the session on legislation, considerable attention was given to a comparison of hospital legislation in the different provinces, to special problems such as floaters, traffic accidents, definitions of residency and indigency, etc., to the question of stricter oversight by governments of hospital development and distribution, to workmen's compensation boards and to federal arrangements for sales tax exemptions, the care of veterans, Indians, marines, etc.

Construction and Equipment

An excellent report on this subject was submitted by a comprehensive committee which made a study of a number of aspects of this subject, as for instance, operating room lighting, isolation facilities, psychopathic annexes, the dietary arrangements, the physiotherapy department and other features. The report on insulation is of particular interest in that it points out the need for special arrangements in northern latitudes for heat conservation and control, features not adequately considered in arrangements adopted from less extreme climates.

Public Relations

This study concentrated on an analysis of the extent to which hospitals in Canada are meeting the needs of the people. While conditions as a whole are very satisfactory, it was pointed out that there are large areas in rural districts not adequately served, that there is a shortage of accommodations for early mental cases or for convalescent and chronic patients. The necessity of the hospitals participating more actively than at present in the health program of the community was emphasized. Pay diagnostic clinics for larger centers were also considered, as well as the greater development of out-patient departments. The many problems of the smaller hospital were reviewed in an excellent report by H. S. Wright of Inverness, N. S., in which were reviewed the special difficulties associated with isolation facilities, radiological and dietetic service, the segregation of patients, visitors and other small hospital problems.

Finance and Administration

The committee on finance under the chairmanship of Leonard Shaw of Saskatoon recommended the early development of a standardized form of accountancy which would be obligatory to all hospitals in the various size and type groupings. The establishment of a collection department within the hospital was preferred to an outside agency! Also no flat rate plan can be successful unless all cost factors are considered and a proper reserve set up to safeguard normal progress. Group hospitalization with the proper safeguards and under the control of the hospitals was recommended.

In the report on administration presented by Dr. L. S. Williams of the Winnipeg Children's Hospital, the chaotic state of hospital accounting and the necessity of establishing comparable methods, particularly if per diem costs are to be compared, was emphasized. It was decided that all hospitals be urged to adopt the unit accounting system with clearly defined units of cost.

Dr. R. T. Washburn, superintendent of the University Hospital, Edmonton, presented the interim report of the committee on research. This committee has developed a five-year program of study on tuberculosis in nurses, the final report of which, judging by work already accomplished, should prove a very valuable contribution.

The program concluded with a joint session with the Manitoba Medical Association for a discussion of the relations between the medical profession and the hospital.

By way of contrast with the heavier duties of the sessions, the delegates at the Thursday luncheon enjoyed an excellent address on "Prairie Pathways and Peoples" by Dr. D. A. Steward, superintendent of the Ninette Sanatorium, Manitoba, and also participated in the dinner dance of the Manitoba Medical Association, sitting in convention at the same time.

Officers elected are as follows:

Honorary President, Hon. R. B. Bennett, K. C., P. C.

Honorary Vice-President, Hon. Col. Murray Maclaren, C. M. G., P. C., M. D.

President, F. W. Routley, M. D., Toronto.

First Vice-President, W. R. Chenoweth, Montreal.

Second Vice-President, Rev. Mother Allaire, Montreal.

Secretary-treasurer, G. Harvey Agnew, M. D., Toronto.

Executive committee, J. M. Coady, LL. B., Vancouver; Leonard Shaw, Saskatoon.

U. S. Loans $425,000 to Sayre Hospital

Robert Packer Hospital, Sayre, Pa., has been formally notified through its state advisory board, Public Works Administration, that the federal government has approved its application for a loan for $425,000 for new construction. Howard E. Bishop, superintendent, has announced that contracts for the building would be let at once.

The hospital is to pay 5 per cent interest.

This is one of the first hospital loans to be made under the federal public works program, as explained in Hospital Management in the last issue.

Hospitals receiving public funds for the care of indigents are eligible for such loans. Details are available at each state advisory board, Public Works Administration office.

MSGR. FISHER DEAD

The Right Rev. John P. Fisher, secretary to Bishop Morris of Little Rock, Ark., and editor of the diocesan paper, died recently after a brief illness. Monsignor Fisher was actively interested in hospital work, being diocesan director of Catholic hospitals, and he was serving his second term as president of the Arkansas Hospital Association at the time of his death. His death will be a great loss to the hospital field especially in the South.

15 Years Ago—THIS MONTH—10 Years Ago

From "Hospital Management," November 15, 1918

Jane A. Delano, director, department of nursing, American Red Cross, asks continued cooperation of hospitals and nursing schools in training of nurses' aids.

Ban on hospital construction, due to war needs, modified.

From "Hospital Management," November 15, 1923

Detailed report of silver jubilee convention of A. H. A. at Milwaukee, presided over by Asa S. Bacon.

National Hospital Day Committee has its first booth at A. H. A. meeting.

1,176 hospitals approved by American College of Surgeons (less than half of total of 1933 list published last month).

American Dietetic Association votes for full time executive secretary at Indianapolis meeting.

Some Qualifications of Successful Executive Housekeeper

By MISS A. WALDEN

Member, Philadelphia Chapter, N. E. H. A.

THE position of executive housekeeper today has been raised to the dignity of a profession in some instances due to the exacting qualifications demanded of the person holding this post, owing to the rapid growth of hotels, clubs and hospitals. The job requires certain specifications, therefore she must be trained to measure up to these specifications.

Personality will be of untold value to her, and tact will be one of her greatest assets. Having developed character that is positive, creative and active, she will produce effective leadership. She requires poise and the ability to establish and maintain cooperative relationships with the heads of other departments. She needs to analyze facts quickly, to draw fair conclusions, have broad sympathies and a keen interest in human nature.

Service must be her watchword; she must have an interest in the welfare of her employes and must realize that it is more important to inspire good will than to instill fear, that they are of flesh and blood and have aspirations like those in authority.

It is essential that she acquire a background of knowledge, with a fund of information gained through practical experience.

She must have an understanding of psychology as a means of dealing with personnel problems, and of accurately assigning employes to occupations for which they are best suited, thereby attaining a high standard of efficiency, and reducing labor turnover.

She must also have a knowledge of economics to buy intelligently and so to administer her budget to secure maximum results at a minimum of expenditure.

She must also have a knowledge of chemistry, which involves the correct uses of soaps and detergents in the various cleaning processes and a knowledge of textiles, which will guide her in their selection, care and renovation.

Organization is an important factor in the housekeeping department; without this it is not possible to obtain efficiency or economy. The executive housekeeper should have the duties of all her workers so clearly scheduled that she will know exactly in what part of the house each one is working at any hour. To do this, it is essential that she has her office where she can plan and schedule the work of each employe, assistants and inspectresses included.

Clearly defined relationship of authority and responsibility should be established, definitely assigning every duty and placing no one in subordination to two others in the same source of responsibility.

Competent assistants or inspectresses should be able to train workers according to the methods set down by the housekeeper and see that these methods are carried out systematically. Regular meetings for instruction of workers are highly beneficial. Demonstrations in the making of beds and other duties are also useful for training.

The executive housekeeper often has control of the laundry and linen room.

It will be necessary for the executive housekeeper in some cases to have a knowledge of catering. She may even be called upon to demonstrate the cooking of various dishes with which all cooks are not always familiar.

Since hospitals, hotels and other institutions vary greatly in size, the methods of procedure adopted in the housekeeping departments must necessarily vary, but the qualifications demanded of the executive housekeeper are essentially the same.

Many social and economic facts are affecting all careers for women in many ways, creating the necessity for constant study of their specific field. The educational benefits to be gained through membership of the National Executive Housekeepers' Association have been of great value and inspiration to its members.

SHORTER NURSING DAY

Among the hospitals that recently reported the operation of a shorter working schedule for nurses are the Two Rivers Hospital, Two Rivers, Wis., Mrs. Myrtle Burgener, superintendent, and Memorial Hospital, Albany, N. Y. Mrs. Burgener reports that no change in salary was made when a 40-hour week was put in effect in September and that it was necessary to employ five more full-time nurses. The Memorial Hospital formerly had a 12-hour day schedule.

Why I'm "At Home" to Salesmen One Day in the Week

By S. CHESTER FAZIO
Superintendent, Rockaway Beach Hospital, Rockaway Beach, N. Y.

COMMERCIAL concerns sometimes consider the quality, durability, and price of articles to be purchased for use in factory or office to a degree which to the average person may seem almost ludicrous. However, the need for careful purchasing soon becomes apparent when one realizes the accuracy and perfection of service required of a machinery part, and the quantity of a small item ordered throughout the year (which may be the cause of surprising cost in the annual expenditure) such as the article which is the standard criterion of an economical office manager in the disparaging comment, "He counts paper clips."

In the hospital there is urgent necessity for instant availability of many items and dependability of service, so that it is equally if not more important for an institution carefully to consider the reputation of firms and the quality of goods. In regard to quantity and price there is again a similar condition, although perhaps on a smaller scale, as economy of operation is necessary, and there are many small items of which the stock is frequently depleted through use or which must be replaced due to loss or breakage. Here the gauge of disaster seems to be thermometers, the bane of the probationer. It is, therefore, essential that the purchaser of supplies for the hospital be familiar with the standing of various manufacturers and wholesale houses, the service they accord, the quality of the numerous makes and brands, and the fluctuations in market price.

Contracting for supplies regularly replenished is one way to decrease the cost of certain items. Just as coal is less expensive during the early summer months, so also in other merchandise there is often a seasonal demand and slack and rush periods for some manufacturers. So that production may be more equalized and a more steady income assured, these firms are willing to lower the price on contract. Some purchasers favor a yearly contract which obtains the lowest price, but I prefer a monthly contract and find that in addition to what I consider other advantages, an average of the prices shows very little increase in total cost on this basis. In either case a stipulated clause will provide satisfactorily for any possible drastic price reductions before the expiration of the contract.

In a large hospital the purchasing is very frequently one of the matters delegated to one of the superintendent's assistants. The superintendent in capacity of chief administrator keeps informed, of course, of the quality of products, prices, etc., but is relieved of the time-consuming interviews and actual transactions. However, in the hospital up to about 150 beds, and more especially in the community hospital, it is generally necessary for the superintendent personally to attend to the many details of hospital administration and routine. For this reason each day is apt to be a full one and often a long one, therefore, an hour and even one-half or one-quarter of an hour's time assumes an almost disproportionate value.

One of the interruptions of the day which is likely to seem most annoying is to be told that a salesman wants an interview. Visions of a long-winded, tiresome persistence regarding an article with which one is already stocked, which another firm has satisfactorily supplied the institution for some time, or for which one has no use whatsoever, immediately pass through the mind, and the superintendent refuses to be disturbed. Permanent instructions may even be issued to the desk clerk or secretary to the effect that the superintendent is not even to be told of the call, except in stipulated cases.

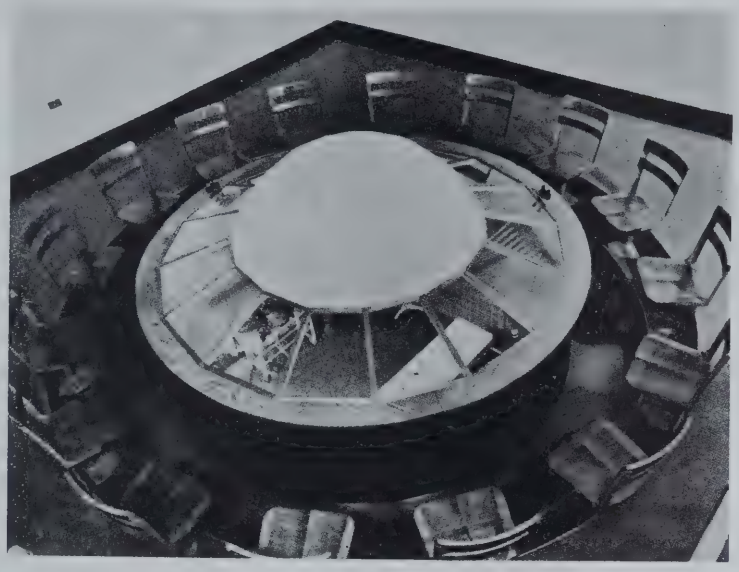
I have found from several years' experience that such procedure is inadvisable, particularly for the administrator of a community hospital which, as the title rather implies, is apt to be in a suburban district. The superintendent of any institution in a city may, if so inclined, visit the showrooms or even the factories of the manufacturers of various items, or inspect the installations at other hospitals in a minimum of time. True, the community hospital may be rather a short trip from a city, as Rockaway Beach Hospital is from New York City. The time element, however, predominates and it is probable that the majority of superintendents will agree that due to various conferences, etc., it is difficult to leave the hospital for an entire day, and when one does there are almost certain to be numerous other matters of importance which will occupy every minute of the day.

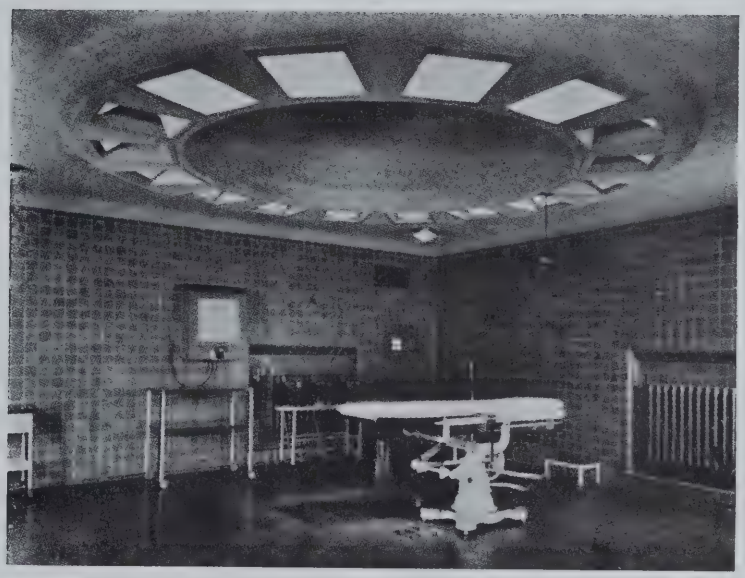
Many firms, of course, advertise in the hospital journals and by mail, and the superintendent does well to note the information thus conveyed. However, many questions regarding the products may require an explanation before the superintendent wishes to order them. This involves engaging in a perhaps lengthy correspondence or at least writing to request a salesman to call. This method has many factors in its favor for some merchandise, but for others a personal interview is often preferable. Moreover, a salesman may have samples or models and can more clearly demonstrate certain important points or features while at the institution.

The effective solution for my own case in this matter is probably the same method used by many other superintendents, that is, regularly to establish one specific day of the week for interviews, and that day and no other. This, of course, may sound absurdly simple to some and yet to others may not sound at all practical.

The main objections offered is that a superintendent cannot be definitely assured that he or she will be at liberty the same day of each week and that if so such time could be better utilized for the numerous problems which await the all essential "time" to attend to them.

I am convinced, however, that much of value can be learned during these interviews regarding new articles worthy of investigation and consideration, and much interesting data regarding the prices of standard products as offered by different firms, which sometimes show a marked variance, and through which comparison the hospital is saved a considerable amount during the course of a year. Furthermore, a firm with which one deals regularly may be very satisfactory in every respect and the purchaser feels it is only fair and





The illustration at the top shows the observation gallery above an operating room of the Institute of Ophthalmology, Presbyterian Hospital, New York City. This gallery obviates the presence of visitors in the operating room, but gives the visiting physicians and students a complete view of an operation, with details in sharp focus through the use of binoculars. Sixteen observers may be seated around the dome, with the operating table about ten feet below their eyes.

The use of this gallery obviates the necessity for gowns, and eliminates noise, chance for infection, etc. At the same time, through a microphone and amplifier the comments and remarks of the surgeon are audible to the observers.

sensible to continue to do so until such time as they may not warrant further orders. Nevertheless, it is not at all unfair and certainly not unwise to let the salesman (and hence the firm) know that the field is not completely closed to other firms and that there is competition for them to consider.

Regarding the actual time thus consumed in this day devoted to interviews by actual record one will find that it is much less than one would believe. There is not apt to be an overwhelming number of salesmen arrive on any one day and some interviews are naturally rather brief, and by arranging the day to allow for such interruptions I find that many of the smaller matters which accumulate during the week can be satisfactorily attended to on that day.

This system has several advantages for the salesman also inasmuch as actual time required to reach the institution is not wasted; time lost between trains or by travel en route if by auto in the case of suburban hospitals; carfare, or mileage if by auto, for which in some instances the salesman is not reimbursed; and repeated calls with the attendant inconveniences and expenses just mentioned, are eliminated.

Some superintendent may feel that the salesmen's itineraries may be such that they cannot arrive at their hospital on a specific day and that he or she will grant the interviews for the interest of the hospital's purchases at such time as they call. However, it is really the salesmen's problem and one which most of them seem to be able to adjust to their own satisfaction and best interests, probably operating on the basis that a definitely assured interview is worth two "possibilities."

SAINT JOHN GENERAL HOSPITAL
PATIENT'S COMMENT SLIP No.

The Hospital management would appreciate your co-operation in commenting on the service you have received during your stay in Hospital; also any suggestions with regard to that service which would be likely to improve it. We trust that your stay in Hospital has benefitted you materially, and that you will continue to improve in health, and we thank you for the privilege of caring for you.

M

PATIENT OF { ROOM / WARD

DISCHARGED — DATE

I have been a patient in SAINT JOHN GENERAL HOSPITAL for days, and found it to be as follows

SUGGESTIONS

Discharged by

Signed

At the left is a copy of the patient's comment slip which has been used with such success at Saint John General Hospital, as described in the accompanying article.

It is to be noted that this slip is filled in by patients without exception, despite the fact that no envelope is used.

Do Patients Use "Comment Slips"?

"Yes" Answers This Writer and Adds That It Is Not Even Necessary to Supply Envelope to Enclose Remarks

By DR. S. R. D. HEWITT
Superintendent, Saint John General Hospital, Saint John, N. B.

FROM time to time one notices in the hospital journals articles pertaining to patients' complaints, methods of obtaining and dealing with such.

About five years ago, in the hospital with which I was then associated, we introduced what we termed a "Patient's Satisfaction Slip." Later we changed this to "Patient's Comment Slip," because we found that the word satisfaction suggested the word "satisfactory" or "satisfied," and a great majority of our "satisfaction" slips were filled in that fashion.

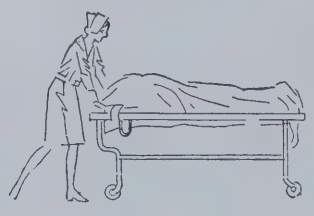
I have since introduced the comment slip in my present hospital, and after at least four or five years' experience with it I have reached the conclusion that it is at once a justifiable method, and I also believe an accurate method, or as accurate as any such scheme can be, of obtaining patients' cooperation in the completion of the form, and that in a way which reflects and states the thoughts which the patients have concerning their care in the hospital. Moreover, it is always the policy to inquire of our patients when in the hospital as to their comfort and care, the quality of their food, and other such matters as pertain to the care of the sick. Our experiences gained from this sort of inquiry, and the replies received, coincide quite accurately with what the patients write on our comment slips.

I explain this because it may be said, and has been said, that the patients will hesitate to write their views on a form which is not put in an envelope. My experience does not lead to any such conclusion.

The actual comment slip, which appears with this article, is self-explanatory, and as such is clearly understood without any explanations being necessary on the part of the hospital staff. When a patient is listed for discharge from the hospital they are presented with a comment slip and their cooperation asked in completing it.

The portions filled in by the hospital staff are the following: Number—in the upper right hand corner, which is patient's admission number. Room or ward; and Discharged by—the latter being the name of the nurse who carries out the discharge of the patient.

These comment slips are collected by the floor supervisors and turned into the office of the superintendent of nurses early the following morning and are on my desk at 9 a. m., previously having been checked over against the list of discharges to see if any have been missed. This is a very rare occurrence and I can recall only one instance within the last eighteen months where the completion of the slip had been declined by the patient. We find that the patients are very glad to complete them, and each slip is read over carefully, and if there is a suggestion—and we often get some very splendid suggestions—it is listed, or a complaint.



A personal note is written by myself to the patient in acknowledgment of the complaint or suggestion, after having gone into the details of the former. Where indicated, an addressed, stamped envelope is forwarded with the hospital letter, asking for the person's further cooperation in giving more detail on the subject under discussion.

Complaints

Should a patient list a complaint of any moment on the comment slip, that information is transmitted at once by the floor supervisor or senior nurse to the training school office or the superintendent's office, and that patient is seen before he or she leaves the hospital. This, I am very glad to say, is very seldom necessary.

Occasionally the patient's comment is not quite clear, and in this instance the supervisor or the training school office staff goes into the matter and attaches an explanation of what is meant.

Finally, each comment slip is filed

away as part of the patient's chart or hospital record, where they are available any time for reference.

I do not believe it good administration to inquire of your patients after they have left the hospital concerning their care and attention while an in-patient. The time to obtain this is while the patient is still in the hospital and while anything in the form of complaint or suggestion is fresh in their mind. Additionally, anything requiring correction is more easily and much better corrected at the time it happens.

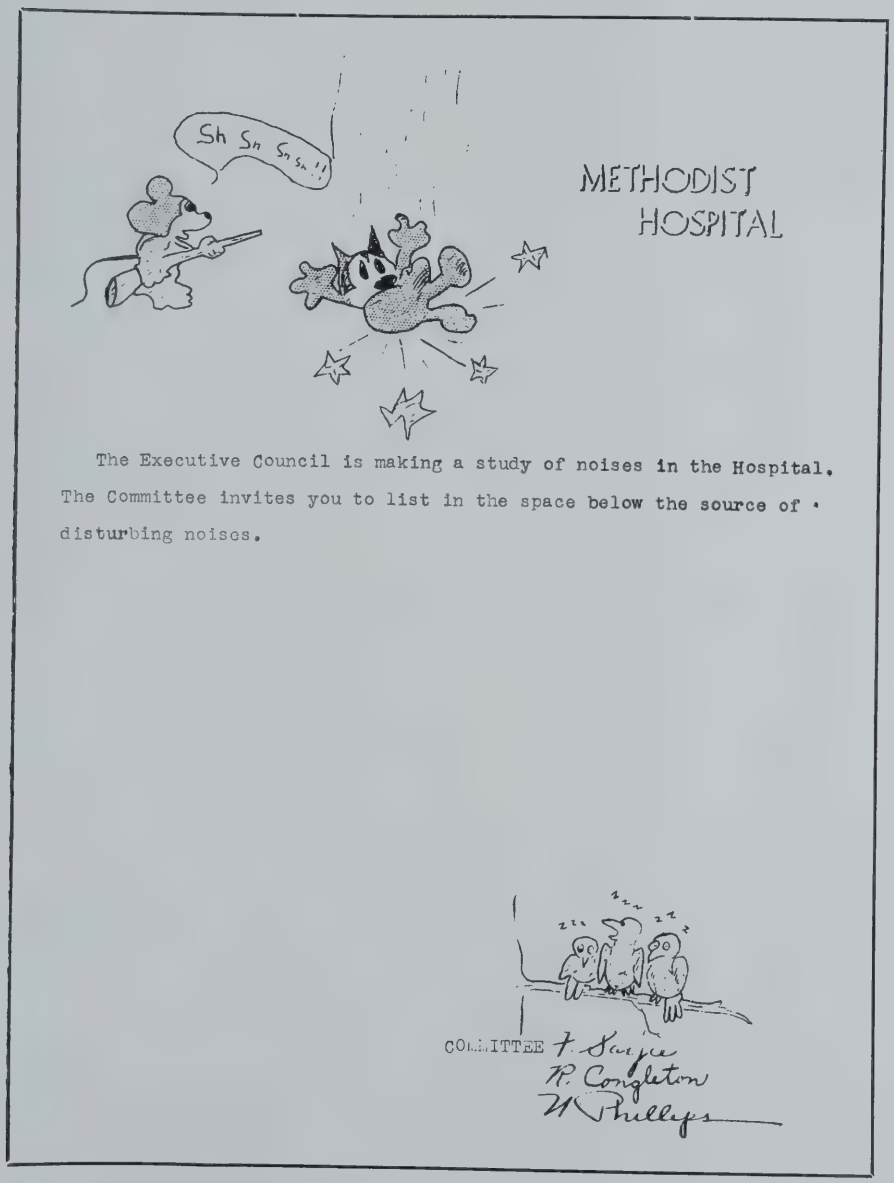
We feel that this is a very good way of obtaining the patient's impressions. We find that the patients are all very glad to cooperate, and we are satisfied they are quite frank in stating what they think, without any regard to any person's feelings in the matter.

Finally, one might add, so far as complaints are concerned, there is, or should be, very little excuse or grounds for complaints. In explanation of this statement I would point out if the patient's attention is of a high calibre there is little opportunity for complaint.

Services to our patients are very closely supervised, and that applies to every branch of the hospital activity, whether its relationship to patient is direct or indirect, and in doing this we feel that we remove the bulk of causes for complaints arising.

To illustrate, may I refer to our laundry procedure which includes, among other things, frequent testing of our finished work, to show presence or absence of alkalinity, acidity or neutrality. Obviously alkalinity or acidity should not exist, and if we keep the reaction of our finished linen neutral we have eliminated a cause of irritation which frequently happens to patients' elbows and knees when proper rinsing or neutralizing has not taken place.

I do not wish to convey the idea that we do not get complaints, as that would not be telling the truth, but I believe our complaints are minimum.



The above is a reproduction of a mimeographed sheet which Methodist Hospital, Indianapolis, used recently in an anti-noise campaign. As to be noted, there is space for the patient to jot down sources or causes of noise which are disturbing him or her. "We are having a lot of fun," writes Dr. John G. Benson, general superintendent, in regard to the leaflet," and believe me, it is getting us somewhere."

800 Registrants at A. D. A. Meeting

The annual meeting of the American Dietetic Association at Chicago in October attracted some 800 members, despite the general economic situation. The program, as published in the last issue, stressed numerous professional and technical subjects, but the session under the direction of the administrative section was also of absorbing interest. The work of approving hospital courses for student dietitians received a great deal of attention as in the past. New Officers, section chairmen and nominating committee members are:

OFFICERS

President, Quindara Oliver Dodge, Simmons College, Boston.

President-elect, Laura Comstock, Eastman Kodak Company, Rochester, N. Y.

Vice-president, Jean M. Stewart, Stanford University Hospital, San Francisco, Calif.

Second vice-president, Ruth Atwater, National Canners Association, Washington, D. C.

Secretary, Margaret Ritchie, Battle Creek College, Battle Creek, Mich.

Treasurer, Ella M. Eck, Billings Hospital, University Clinics, Chicago.

COMMITTEE CHAIRMEN

Administration—M. Faith McAuley, Chicago.

Community Education—Mary I. Barber, Kellogg Company, Battle Creek, Mich.

Diet Therapy—Lute Troutt, Indiana University Hospitals, Indianapolis.

Professional Education—Mary M. Barrington, Harper Hospital, Detroit.

NOMINATING COMMITTEE

Chairman, Dr. Kate Daum, University Hospital, Iowa City, Ia.; Aileen Brown, Medical College of Virginia, Richmond; Helen E. Gilson, Pennsylvania Hospital, Philadelphia; Reeva Hinyan, California Hospital, Los Angeles; Ursula S. Senn, Buffalo City Hospital, Buffalo, N. Y.

START GROUP PLAN

Garfield, Sibley, Emergency, Columbia, Episcopal, George Washington, Georgetown, National Homeopathic and Providence Hospitals of Washington, D. C., are working on plans for group hospitalization that are expected to be completed in two months, it was announced recently.

Experience of Memphis Hospital with Group Hospitalization

By WALTER FRANSIOLI
Auditor, St. Joseph's Hospital, Memphis, Tenn.

AFTER conferences with other local hospitals and an endeavor to work out some plan satisfactory to all who cared to participate, the first offering of Group Hospitalization in Memphis was made by St. Joseph's Hospital. Methodist Hospital and Gartly Ramsay Hospital several months later decided to participate in this plan and joined St. Joseph's Hospital in operating through the same sales agents with identical service and rate.

Ninety cents per month is charged for each individual insured, who is required to be between the ages of 16 and 60, employed, and in good health when the insurance contract is applied for. Housewives and children under 16 were not included. The consensus was to limit the experiment to employed individuals until experience determined the advisability of including others.

It was felt that after the plan had been in successful operation long enough to accumulate a reasonable surplus, it would then be ample time to take whatever action experience suggested in reducing or increasing rates.

The Baptist Memorial Hospital here independently decided to experiment with group hospitalization, make its own sales and collections direct. Its rate is 75 cents per month for employed persons of either sex; housewives and children under 16 are partially protected by the payment of an additional dollar per month. This makes a total of $1.75 for each family group irrespective of the number of children less than insurable age.

From April 21, 1933, until November 2, 1933, St. Joseph's Hospital issued a total of 359 group hospitalization memberships, of which 76, or less than 20 per cent, were subsequently discontinued, leaving the present net membership 283.

No occupational segregation or exception has so far been made and the majority of the present members are office workers or sales people, of both sexes, presumably preferred health risks.

Our 283 present members are about evenly divided as to sex; 142 are males, average age 33.62, and 141 are females, approximately 40 per cent of them married, average age 31.31.

The combined average group age is 32.47 for all members and about 17.8 per cent of the total risks so far accepted are over 40 years old.

Six members pay annually, seven semi-annually, 54 quarterly, and 216 remit monthly. They are all employed by about 45 concerns.

St. Joseph's Hospital has cared for nine members under this plan. One man, 36, was admitted for tonsillectomy, and eight women with ages and ailments as follows: 43, breast tumor; 23, appendectomy; 30, tonsillectomy and nasal operation; 25, vaginal operation; 22, adhesions; 29, tonsillectomy; 29, anal fissure; and 23, laparotomy. These are listed in the order in which the patients were admitted.

This experience has, of course, necessitated a change of policy concerning the admission of chronic cases, either surgical or medical.

St. Joseph's Hospital has received from insurance income up to November 2, 1933, a total of $631.48, while the total charges for the hospitalization of these nine patients, *all surgical cases*, at usual rates for an aggregate of 77 days amounted to $564.55.

Allison Woodall and William Furneaux, a local partnership operating through the National Hospitalization Systems, Incorporated, are very satisfactorily handling the sales and collections for St. Joseph's Hospital, as well as the Methodist Hospital and Gartly Ramsay Hospital.

These agents at their own expense provide a centrally located up-town office and assume the risk of obtaining and maintaining a satisfactory enrollment for the participating hospitals, acting as a very valuable intermediary between them and applicants for insurance.

The present rate for the hospitals mentioned is 90 cents per month for each individual insured, with no reduction for quarterly, semi-annual or annual prepayment of dues. Of this $10.80 per member per year, the sales and collection agents receive for their services $3.60 (one-third) and the hospital issuing the contract receives the remaining $7.20 (two-thirds).

In applying the person insured specifies the hospital selected and separate policies are issued by each participating hospital for every individual risk assumed.

St. Joseph's Hospital has not had sufficient experience with the operation of this group hospitalization plan intelligently to determine if the proportion of the present rate is sufficient to protect it in the hazard assumed.

Group Hospitalization Plans in West Virginia

By JOE W. SAVAGE
Executive Secretary, West Virginia Hospital Association, Charleston, W. Va.

THERE are two group hospitalization plans now being operated in West Virginia.

Hospital Service, Inc., began operating in Charleston January 1, 1933. Every hospital in the city is a member of this group, which also includes the Coal Valley Hospital at Montgomery, about 20 miles east. These hospitals own Hospital Service, Inc., and employ a business manager who has charge of all the business affairs. Practically all of their funds come through payroll deduction. They now have about 1,100 subscribers and a total of about 2,800 persons eligible.

The second organization is Associated Hospitals, Inc., of Bluefield. Both the hospitals in Bluefield and one or two neighboring hospitals own and operate Associated Hospitals, Inc., which has 1,000 subscribers. It began operating about the first of April, 1933, and its plan is almost identical with the plan of Hospital Service, Inc.

The following from a leaflet issued by Hospital Service, Inc., Charleston, gives features of the plan:

1. Your choice among seven member hospitals: *McMillan Hospital, Mt. State Hospital, St. Francis Hospital, Staats Hospital, Kanawha Valley Hospital, Charleston General Hospital, Coal Valley Hospital.*
2. Hospital care for an aggregate of 42 days in each year.
3. Private room or ward bed. At your option at the time you apply for membership.
4. Meals.
5. General nursing care.
6. The services of resident hospital

(Continued on page 45)

THE HOSPITAL ROUND TABLE

Dispensary Costs

Some interesting facts about the effect of the depression on the finances of an out-patient department and some interesting figures concerning the cost of different types of diagnostic and treatment services of a clinic are found in a recent leaflet issued by The Boston Dispensary, Boston, Mass., Frank E. Wing, director, entitled "Health Services in a Year of Depression." The following excerpts from this leaflet show comparisons with 1925, which was selected as a normal year:

MORNING CLINICS
(Free and Part Pay)

	1932	1925
Visits by patients	135,179	97,492
Entirely free	54%	30%
Per visit cost to Dispensary	82.3c	$1.10
Aveage paid per patient.	26.5c	50.5c

EVENING PAY CLINICS
(For Working People of Small Means)

Visits by patients	35,759	43,293
Entirely free	6.8%	11.9%
Per visit cost to Dispensary	$1.11	$1.04
Average paid per patient	90.9c	89.1c

Drop in attendance due to unemployment. Patients had to transfer to free or part pay service in morning clinics.

PHYSICIAN'S SERVICE IN THE HOME

Visits by doctors	22,611	6,479
Per visit cost to Dispensary	62.5c	75.5c

DIAGNOSTIC HOSPITAL

688 patients given 3,826 days' care in 1932

Cost per day to Dispensary	$6.63
Average paid per patient per day	1.13

PATHOLOGICAL LABORATORY

	1932	1925
Number of tests	67,999	36,459
Cost per test	23.1c	37.6c
Average paid per test	3.2c	3.0c

X-RAY DEPARTMENT

Number of examinations	4,907	2,761
Cost per examination	$2.42	$2.51
Average paid per examination	57.1c	1.37

PHARMACY

Number of prescriptions.	44,252	46,591
Entirely free	60.6%	38.0%
Cost per prescription	28.2c	42.6c
Average paid per prescription	24.4c	43.3c

Unique Club

Brokaw Hospital, Normal, Ill., on November 6 held the first meeting of its unique Progressive Club, composed of members of the administrative staff and having as its objective the education of the public concerning hospitals and activities within the hospital. The meeting was held in the nurses' lecture room and was open to the public. Similar meetings are scheduled on the first Monday evening of each month from November until June. At the final meeting Mr. and Mrs. A. G. Hahn of Deaconess Hospital, Evansville, Ind., originators of the Evansville plan of hospital educational activity, will speak under the auspices of the club on features of the Evansville plan.

Nursing, anesthesia, obstetrical problems, laboratory, occupational therapy, hospital economics, are some of the topics scheduled for the club meetings. Besides inviting the public to the meetings, announcements and reports of the different sessions are written up in the local press. Miss Macie N. Knapp is superintendent of the hospitals, and the others who are members of the Progressive Club and who will participate in the meetings are: Miss Maude Essig, director of nurses; Miss Wilma Senour, practical instructor; Miss Elaine Strayer, laboratory technician; Miss Velma Arnold, operating room supervisor; Miss Ruth Munson, obstetrical supervisor, and Miss Hazel Phares, medical supervisor.

How A. H. A. Helps

In connection with an appeal for financial support by hospitals of this country for a full time representative of all hospitals in Washington, Dr. N. W. Faxon, president, A. H. A., in a letter to all hospitals, summarizes some of the services that the association, in cooperation with the Catholic and Protestant associations, has rendered:

Here are a few accomplishments that have resulted in the saving of considerable sums to every hospital and, in the aggregate, of millions of dollars for the entire hospital field:

1. The American Hospital Association secured the exemption of all hospitals from the collection of Federal inheritance tax, on bequests left to hospitals.

2. The Legislative Committee successfully opposed the increase of duties on surgical instruments and scientific equipment, glassware, and supplies under the present tariff law.

3. The Committee on Veterans' Care of the American Hospital Association was largely instrumental in having the government adopt its present policy of curtailing the construction of Federal hospitals to take care of non-service connected disabilities, except for tuberculous and nervous-mental cases.

The Joint Committee, representing the American, Catholic, and Protestant Hospital Associations, has functioned during this year. The work of this Committee has been in the interests of all our hospitals. As a result of the committee's efforts, millions of dollars have been saved our hospitals.

Among the noteworthy accomplishments of the Joint Committee are:

The decision that "hospitals do not come within the purview of the NIRA." Hospitals were saved hundreds of thousands of dollars in increased payrolls. Every hospital in this country not supported by taxation was benefited.

A ruling from the Treasury Department exempting the payment by hospitals of the 5 per cent tax on dividends on securities held in trust for hospitals.

A sympathetic attitude on the part of Hon. Harry L. Hopkins, Federal Relief Administrator, to reimburse hospitals for the care given the indigent and unemployed sick.

A sympathetic consideration upon the part of the departments interested in exempting hospitals from the provisions of the processing tax. The committee believes that such exemption will be granted, if not complete exemption, at least a refund of a considerable portion of any processing tax collected.

The committee has asked that in all codes submitted, hospitals be put in the same classification as other relief organizations.

The committee is giving close consideration to any laws introduced in the coming session of Congress that may in any manner affect hospitals.

The committee has secured an understanding with the Bureau of Internal Revenue that any legislation adopted regulating the use of alcohol for scientific purposes, and spirituous liquors for therapeutic purposes, will not impose an additional tax upon our hospitals.

The Joint Committee is deeply impressed with the necessity for having a representative of the hospital field in Washington, to press the advantages already secured, keep close tab on codes that may be presented containing features disadvantageous to our hospitals, and to watch closely proposed legislation introduced in Congress.

Form Tucson Council

As a result of the inspiration and encouragement received at the American Hospital Association, a local hospital council, or association, has been formed at Tucson, Ariz. Dr. S. H. James of the Veterans' Hospital is the president of the group. Emma L. Mau, R. N., superintendent, Fairview Rest Manor, who was much impressed with the value of a local council, as mentioned frequently at the Milwaukee sessions, was temporary secretary of the organization meeting, and Jacob Gunst temporary president. Miss Mau made an interesting report of the A. H. A. convention. Mayor Henry O. Jaastad assured the new organization of his interest and promised the services of Thomas Elliott, city attorney, if required for legal advice. Miss Mau in her report called special attention to the helpfulness of Dr. N. W. Faxon, A. H. A. president, in suggestions at Milwaukee regarding the work of a council.

Duluth Saves Money by Closing Its Contagious Hospital

Contract with Two Non-Municipal General Hospitals Results in Good Care of Patients at Considerable Saving to Tax Payers

By JAMES McNEE

Superintendent, St. Luke's Hospital, Duluth, Minn.

DULUTH, a city of about 102,000, had in January of 1932: Two general hospitals with a capacity of 560 beds; two private hospitals of 80 beds; one county hospital of 85 beds; and one contagious hospital of 32 beds; a total of 757 hospital beds.

The contagious hospital, a three story building, was built in 1909. It had two wards and four single rooms on the third floor, and two wards and two single rooms on the second floor. The first floor was used for offices and living quarters of the staff. Diphtheria cases were admitted to the wards on the third floor and scarlet fever patients to the wards on the second floor. The private rooms were used for other types of cases.

In January of 1932, at the suggestion of Dr. A. J. McLaughlin of the United States Public Health Service, Warren S. Moore, Commissioner of Public Safety of Duluth, requested that the two general hospitals submit bids and proposals for the care of city contagious patients. The proposals were presented to the executive committees of the medical staff, and the governing boards of the two hospitals, and received their approval. Contracts were drawn for a period from April 15, 1932, to December 31, 1933. The city guaranteed each hospital a minimum of 500 hospital days per year with a maximum of 750 hospital days per year. The rate per patient day charged to the city by the hospitals, is $4, which includes all hospital care necessary except the use of the surgical department, anesthesia and dressings.

The city contagious patients are under the supervision of the city epidemiologist.

The contagious wards are located in the hospitals. A section of each hospital has been remodeled and equipped as self-contained units, having their own kitchens, sterilizing rooms, etc. Each hospital has a capacity of 10 beds in their contagious departments, but are so arranged as to be able to accommodate 16 or 17 patients if necessary. The units are flexible in order that several types of contagious cases may be taken care of at one time. The departments are under the supervision of graduate nurses who have received post-graduate training in the care of infectious diseases. Procedures and technic for the care of patients admitted to these departments, including the admission of patients, the care of dishes, linen, contaminated material, garbage, instruments, etc., as well as the nursing care of the patient, were prepared by the hospitals and approved by the city health department. The supervision of aseptic technic is the most important part of isolation care.

I quote from a paper by Dr. F. G. Carter, presented at the American Hospital Association meeting in 1930:

"Proper isolation is, in my opinion, the storm center of most of our difficulties. Medical aseptic technic is expensive to maintain and requires close, constant, competent supervision. If it is to be worthwhile, there can be no compromise in its application. Scrupulous observation of such technic is irksome and distasteful to those not accustomed to its use and without eternal vigilance lapses in its employment are frequent. Generally speaking, there is too much of the 'take a chance' attitude toward medical asepsis, too much gambling with results. On the other hand, penalties for violation of principles of medical asepsis are at least as great as those imposed for violation of the principles of surgical asepsis."

Dr. Fred Adams, medical officer of health of Windsor, Ontario, presented a paper on "Infectious Diseases in General Hospitals" at the American Hospital Association meeting last year, and stated that there are certain main considerations to be kept in mind in connection with the hospitalization of infectious diseases. I quote:

"1. Infectious diseases are an important part of total illness. The best medical and surgical and nursing care is necessary. The difference between the best care and ordinary care may be the difference between a permanent paralysis, a permanently damaged heart, etc., and complete recovery. The infectious diseases are self-limited diseases. The ideal in care is complete recovery. To attain this ideal in hospital treatment the infectious hospital must be modern and fully equipped, and nursing, surgical, medical, and specialist care must be the very best. In short, the present day isolation hospital must be up to the standard of a first class general hospital. The 'pesthouse' type of isolation hospital is a thing of the dark and ignorant past.

"2. While hospitalization must be the best in equipment and personnel, costs must be kept within reason. Many of the patients will not be able to pay.

"3. Infectious diseases are to a great degree seasonal and the fluctuations in usage of an isolation hospital are greater than in a general hospital.

"4. It is neither desirable nor necessary to hospitalize all cases of infectious diseases, but it is necessary to hospitalize a certain number for the good of the patient, for the protection of others, and so as not to interfere with the carrying on of a business.

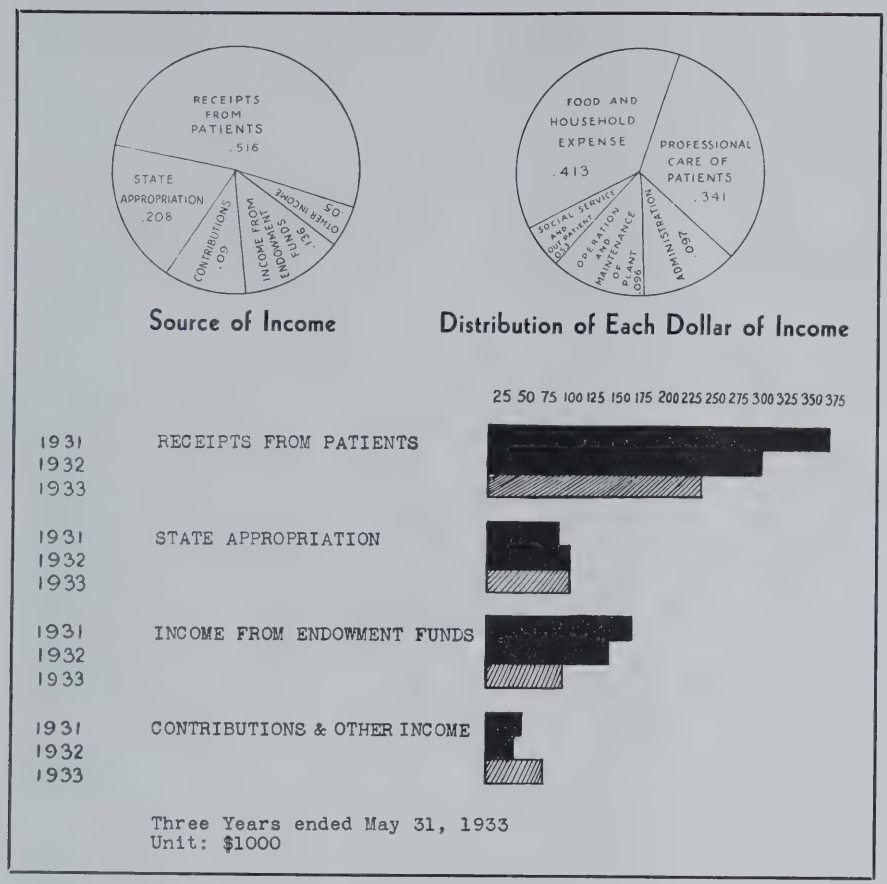
"5. Our knowledge of the ways by which infectious diseases are in fact communicated has been enormously increased in the last 30 years. We are quite sure that they do not travel long distances through the air. Coughing range (6 or 8 feet) is about the limit. Actual contact with a patient or with things recently contaminated by him are important. Disease may be carried mechanically from a patient by a careless attendant's neglecting certain simple precautions, but not otherwise. These considerations are very important from the standpoint of the design and location of isolation hospitals."

In 1928 the Committee on Public Health Relations of the American Hospital Association in its report made the following statement:

"Granting that cities, towns, etc., are responsible for care of the sick with contagious diseases, it is incumbent on them to furnish skilled and efficient care at the lowest cost. In many of the larger cities the hospitals for contagious diseases are not connected with any other hospital, but they are sufficiently large so that they can be maintained at reasonable cost. However, the quality of service, in more than one of such large detached hospitals, is lessened by the lack of an x-ray department, suitable laboratories, etc., and the difficulty of securing the services of competent specialists. It was formerly thought that these services are not needed in a contagious hospital, but they are very necessary and any contagious hospital without them is not in a position to render efficient service to the patients. It is even more true than formerly, for many kinds of contagious diseases are now admitted to contagious disease wards, and as time goes on, it is not unlikely that all kinds of transmissible diseases will be cared for in such wards."

Comparing the cost of the care of

From a paper before 1933 Minnesota Hospital Association Convention.



How Allegheny General Hospital, Pittsburgh, Dr. G. Walter Zulauf, superintendent, pictured its financial activity in a recent issue of "Allegheny General News." How does this distribution of income and expense compare with that of your hospital?

patients with contagious diseases in the general hospitals with that of the contagious hospital, I quote from a report by Dr. Mario McC. Fischer, director of public health for the City of Duluth:

"The following are the actual cost figures from April 15th to December 31st, 1932:

Total hospital patient days.....	668
Total patients	41
Average days per patient.....	16
Average cost per patient.....	$72.55
Average cost per patient per day	$4.53
Total cost to city on contracts..	$2,974.66

"In computing the actual cost to the health department, however, the maintenance of the watchman at the old contagious hospital must also be charged off, as well as the operation of the hospital itself during the first 3½ months of 1932. When this is done, we find that the average cost to the city for hospitalization of contagious disease cases during 1932 was $6.08 per patient per day. This seems high but is still a considerable saving over the average cost per patient per day at the Contagious Hospital during the first 3½ months of 1932 which amounted to $8.50."

From the records of the Contagious Hospital covering a period from 1927 through 1932:

	No. of patients cared for	Total cost
1927.....	136	$13,684.80
1928.....	132	12,620.71
1929.....	151	12,420.25
1930.....	62	11,069.74
1931.....	38	8,932.78
Total.....	519	$58,728.28

The number of patient days during this period is not available, but we find that the average cost to the city per patient for the five-year period was $113.15. The lowest cost per patient was in 1929 in the amount of $82.25, and the highest was in 1931, $234.83 per patient. From our first year's experience as compared to the five-year period preceding we have saved the taxpayers of the city $40.60 on each patient that we have hospitalized.

Our experience in the care of contagious cases in the hospitals of Duluth has extended over a period of about one year. In this short time we have not as yet found any disadvantages. The expected protests from the public and other patients have not materialized. The advantages of having a department for contagious diseases in a general hospital are many. Some of the advantages to the patients are: the accessibility of diagnostic and treatment facilities, both personnel and equipment, also the availability of clinical consultation. The nurse in training finds many advantages in the matter of improved technic. She is able to do better nursing in the hospitals and in the homes and is better able to protect her own health. The intern receives training and instruction in caring for patients with contagious diseases. One adverse comment was obtained from the interns, being the diagnosis of these cases generally is made before the patient enters the hospital.

By adding the contagious departments, our institutions have become more valuable to the community; the hospitals are able to offer better training to nurses and interns; by having a supervisor of isolation technic, the aseptic technic throughout the hospital is improved, and we are assuming more of the total hospital care of our people. The community and the taxpayer are relieved of the necessity of supporting a special hospital, which in most instances is expensive to operate, thereby reducing cost of medical care to community.

PERSONNEL LIST

The annual report of Muhlenberg Hospital, Plainfield, N. J., in its annual report lists the following personnel. The hospital averaged 183 patients a day and its bed capacity is 240 beds, 35 bassinets. Total personnel 298.

GENERAL ADMINISTRATION—1 superintendent, 1 assistant superintendent, 1 bookkeeper, 2 cashiers, 1 secretary to superintendent, 1 stenographer, 3 telephone operators, 1 relief operator, 2 information clerks (nurses) hostesses, 1 doorman, 1 filing clerk, 1 bill clerk.

MEDICAL—20 physicians (consulting), 36 physicians (attending), 5 physicians (house staff).

NURSING—1 director of nursing, 2 assistants to director, 2 instructors, 2 night supervisors, 18 general charge nurses, 70 student nurses, 6 orderlies, 4 maids, 1 houseman, 1 surgical supply worker.

OPERATING ROOM—3 graduate nurses, 2 anesthetists (nurses), 1 orderly, 3 student nurses.

LABORATORY—2 pathologists, 2 technicians, 1 clerk.

X-RAY—1 roentgenologist, 1 technician, 1 porter.

DENTAL—4 dental interns.

DRUG—1 druggist.

RECORD—1 historian.

OUT-PATIENTS—1 graduate nurse in charge, 1 social service worker, 2 clerks, 3 student nurses, 1 porter.

DIETARY—1 chief dietitian, 2 assistant dietitians, 1 chef, 1 pastry cook, 1 private patient cook, 1 night cook, 7 kitchenmen, 3 tray girls, 3 serving room maids.

HOUSEKEEPING—1 housekeeper, 1 cafeteria dietitian, 3 seamstresses, 4 waitresses, 2 dishwashers, 1 dormitory maid, 12 housemen, 10 maids, 1 storeroom man, 1 housemaid.

LAUNDRY—1 head laundryman, 1 assistant laundryman, 11 laundry women.

MECHANICAL—1 engineer, 3 firemen, 1 utility man, 1 carpenter, 3 painters, 3 gardeners.

TRANSPORTATION—1 chauffeur, 1 assistant chauffeur.

Hospital Librarian Must Be Interested in People—and Books

By RAPHAELLA E. SCHWARZ
Assistant Librarian, Veterans' Administration Hospital, Northport, N .Y.

TO the reading public it might seem strange that it is ever essential for libraries to conduct publicity campaigns. It is almost incongruous that an altruistic institution, offering service without asking anything in return, must need take steps to interest patrons. But the fact remains: libraries find it necessary to "sell" their services to the public. In public libraries, where appropriations depend on the estimate of service, the attention of the public must be attracted and held so that service may be increased and measured. In hospital libraries, where the public is more or less permanent, service may more readily be measured; and successful service is an end in itself.

The personality of the hospital librarian is of paramount importance. A scholarly, well-informed person who is more interested in books than in people may be an excellent reference worker, indispensable in certain libraries, but she could accomplish nothing in hospital work. On the other hand, one who is interested in people but whose knowledge of books is limited, can inspire no confidence and, hence, would fail to arouse or stimulate interest in reading. The librarian must be well-balanced, a person whose interest in books and in people combines in personal service.

Human beings are egocentric. It is perfectly normal to be self-interested, self-analytical, and to desire attention from those with whom one comes in contact. In illness, whether physical or mental, this egocentricity is exaggerated, since confinement blocks outer activities, leaving the ego to concentrate upon itself. Consequently, in hospitals, personal attention—a feeling on the part of the patient of the librarian's personal interest—is absolutely necessary. However, this personal interest must always be controlled by professional feeling or it will defeat its purpose.

In a tuberculosis hospital the librarian takes the book cart on the wards, stopping at each bedside to allow the patient to glance at the backs of the books or to skim through them. In the majority of instances, the initiative of the librarian brings the proper books to the attention of the readers. Time and again the patient will say, "I don't feel like reading today." Does the librarian nod and pass by? She does not. She lingers and speaks to him to assure him by her attitude that her chief concern is in his welfare, not in the circulation of books. Chances are that the patient is discouraged and downcast, but stimulated by the friendly discussion may be led to borrow a book that will affect his outlook or, at least, afford him a channel of escape from his bed-brooding.

In a hospital for the nervous and mental, personal contacts are most complicated and important. Constant contact is not only essential, but practically unavoidable. On duty and off duty the patients meet the librarian and expect to be received on a friendly basis. Always the question of reading is raised. "That was a great book you gave me the other day!" is a common remark; and the librarian is supposed to remember what book it was or diplomatically find out.

"I'm going to work on a pillow top and would like a design. Could you help me?" is a usual opening to a casual conversation on the dance floor. The librarian for the moment forgets the music and encourages the patient to make it a point to come to the library the next day and get a book or two on design.

"I'd like to know some points on golf to improve my game," says one patient on the golf course.

"There are several books on golf and other sports in the library. Come over; you haven't been there for a long time," the librarian answers, and she gets ready to drive. More often, however, there are no openings and the librarian herself must find the key to interest the patient in coming frequently to the library. Unlike office people who leave their work behind closed doors, the librarian on a post may spend seven hours on duty, but only half the work is done within the library walls. No matter how attentive she might be behind her desk or in the wards, to the needs of the patients, if she is indifferent to the readers outside they will not come to the library. And then what?

The personal equation enters greatly into library work. Therefore, it cannot be stressed too much that the librarian should make constant contacts, meeting each man on his own level. It is very difficult, for there are the normal prejudices and distastes to cope with, as well as disciplinary problems in the library room. The ideal hospital librarian keeps the respect of patients and furthers their interest in reading as a therapeutic measure.

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DEATH OF MISS SNIVELY

A brief mention was made in the last issue of the death of Mary Agnes Snively, "Mother of Nursing in Canada."

Her death brings sorrow to thousands of Canadian nurses who obtained their training under her wise and inspirational supervision, and to thousands more who revered her as the woman responsible for the high standard of nursing in the Dominion.

The credit of interesting Miss Snively in nursing is due to two young women, Louise Darch and Isobel Hampton Robb, who taught in schools near her and who both became famous in the nursing world afterward. On their advice, she left her home for New York in October, 1882, having finally obtained her mother's reluctant consent, and entered the Bellevue Hospital Training School.

Miss Snively was graduated in 1884, and immediately accepted the position of lady superintendent of the Toronto General Hospital. She assumed her duties on December 1, 1884. She remained for 25 years as hospital superintendent. When she retired in 1910, she handed on to her successor a highly organized school known throughout the nursing world as embodying the highest ideals in nursing. For years Miss Snively belonged to the American Nurses' Association, but it was not until 1907 that she and other outstanding members of the nursing profession were able to organize the first Canadian association. This body included only superintendents of training schools. The next year Miss Snively was the leading spirit in organizing the Canadian National Association of Trained Nurses, with members from coast to coast. In 1924 the name was changed to the Canadian Nurses' Association.

In 1909 she brought added prestige to Canadian nurses by affiliating the Canadian Association with the International Council of Nurses, of which she had been made honorary treasurer when it was organized in 1899. She occupied this office for five years and was a vice-president for four years.

Essential Personnel in 2,000-bed Hospital for Mental Patients

Administration

Executive Office—
- 1 Superintendent
- 1 Stenographer-secretary or 1 institutional secretary
- 1 Steward
- 1 Assistant steward
- 1 Accountant
- 1 Bookkeeper
- 3 Stenographers—Clerk A
- 3 Telephone operators or assigned clerks
- 1 Storekeeper
- 1 Assistant storekeeper with other relief duties

Total 14

Garage—
- 1 Mechanic (charge of motor equipment)
- 2 Chauffeurs

Care of Patients

Nursing—
- 1 Directress of nurses or directress of attendants and such assistants and instructors as the regulations of the State Board of Examiners for the Registration of Nurses require. The number of supervisors, charge graduate nurses, graduate nurses, special nurses, head attendants and attendants may vary according to the building and ward layout of each institution. The total number of nursing and attendant force, including the staff of the school, should not exceed approximately the ratio of 1 person to every 9 patients in the institution. The total number of those engaged in the immediate care of patients should be subject to the approval of the Department of Welfare, since some hospitals may be so built that the general ratio should be exceeded while others may be adequately operated at a lower ratio.

Total approximately 220.

Pharmacy—
- 1 Senior pharmacist

Medical—
- 1 Assistant medical superintendent
- 1 Director of clinical psychiatry
- 4 Senior assistant physicians
- 3 Assistant physicians A
- 1 Pathologist
- 2 Assistant Physicians B
- 4 Stenographers

Total 16

X-ray—
- 1 Technician
- 1 Assistant technician—if work warrants and Department of Welfare approves

Hydrotherapy and Electrotherapy—
- 1 Hydrotherapist
- 1 Assistant hydrotherapist
- 1 Electro therapist
- 2 Assistant electro therapists—if work warrants and Department of Welfare approves
- 1 Masseuse or 1 masseur
- 1 Director of physical education
- 2 Assistant physical instructors

Total 9

Dental Therapy—
- 1 Resident dentist
- 1 Dental hygienist
- 1 Assistant dental hygienist

Occupational Therapy—
- 1 Chief occupational therapist
- 9 Occupational therapists or occupational therapy aids, if work warrants and Department of Welfare approves

Total 10

Laboratory—
- 1 Pathologist
- 1 Technician
- 1 Assistant technician

Auxiliary Activities

Social Service—
- 1 Director social service
- 2 Social service workers or at least one to every 100 patients on parole
- 1 Stenographer-clerk

Clinics—
- 1 Community director or part-time service with the other members of medical staff as assistant clinical directors

Diversions—
- 1 Musical director

Library—
- 1 Librarian

Household

Housekeeping—
- 1 Matron A and such matrons B, maids and janitors as are required subject to the approval of the Department of Welfare

Laundry—
- 1 Laundry manager and such laundrymen, laundresses, and helpers as required, subject to the approval of the Department of Welfare

Dietary—
- 1 Dietitian
- 1 Chief cook and extra cooks depending upon the number of kitchens and approval of the Department of Welfare
- 1 Chief baker
- 1 Baker
- 1 Butcher
- 12 Domestic workers and kitchen helpers
- 6 Waitresses
- 2 Institutional workers for pasteurization plant if required

Total 25 plus

Plant and Grounds

Operation of Plant—
- 1 Mechanical director or chief engineer
- 1 Assistant mechanical director or assistant engineer
- 1 Chief electrician and assistant electrician
- 4 Enginemen or operating engineers
- 5 Firemen and such additional firemen, journeymen and journeymen's assistants as may be needed, subject to the approval of the Department of Welfare

Total 12 plus

Care of Grounds—
- 1 Florist
- 1 Garden hand or groundsman
- 1 Labor foreman or journeyman assistant. Such police and night watchmen as may be necessary subject to the approval of the Department of Welfare

Repairs and Upkeep—
- 1 Foreman carpenter
- 3 Carpenters
- 1 Foreman painter
- 4 Painters

The accompanying tabulation of personnel for a 2,000-bed hospital for mental patients is taken from the "Mental Health Bulletin," October 15, 1933, published by Danville, Pa., State Hospital, of which Dr. J. Allen Jackson is superintendent. The bulletin published in full the report of a committee on the survey of state mental hospitals of Pennsylvania, in which report the accompanying personnel recommendations are included. Everett S. Elwood was chairman of the committee, whose members included Dr. Jackson, Dr. Henry I. Klopp, Allentown State Hospital, and Dr. William C. Sandy, Harrisburg.

1 Mason or plasterer
1 Tinner
1 Police and fire marshal
Such additional carpenters, masons, painters, and assistants as may be necessary, subject to the approval of the Department of Welfare
Total 12 plus

Agricultural Activities

Farm—
1 Farm manager
1 Assistant farm manager
1 Orchardist where needed
11 Farm hands
Total 14

Piggery—
1 Swineherder

Hennery—
1 Poultryman

Truck Gardens—
1 Truck gardener
3 Garden hands according to seasonal needs

Dairy—
1 Dairyman
Milkers depending upon size of herd and mechanical equipment

Industrial Activities

Sewing Room—
1 Seamstress

Tailor Shop—
1 Tailor

Weaving—Hosiery—
1 Foreman

Upholstering—
1 Upholsterer

Printing Department—
1 Printer

Cobbler—
1 Cobbler

Activities of the Auxiliary of Pasadena Hospital

By MRS. FREDERICK J. MILLS

President of Auxiliaries, Pasadena Hospital, Pasadena, Calif.

THE Women's Auxiliary of the Pasadena Hospital was organized in January, 1926, immediately following the grandstand crash during the New Year's parade. A number of women volunteered their assistance at that time in caring for the hundreds of injured at the Pasadena Hospital, and Joseph Howe, then president of the board, realized that it was the psychological moment to organize a women's auxiliary.

The group already interested was called together and an organization formed. Mrs. Carl C. Thomas was elected president. The principal objective at that time was the education of the public to a realization of the hospital's service to the community, and to furnish general assistance to the hospital as the need arose.

Realizing that the best way to arouse interest was to get people to working for the hospital, the following committees were organized: to furnish flowers for trays; to collect and distribute books and magazines each week; to organize groups throughout the city to make surgical dressings; to do the same for sewing surgical gowns; for visiting all free or part-pay patients in their homes following discharge from the hospital. This last committee has been most helpful. It is composed of four married graduate nurses, each of whom gives at least one day a week to visiting discharged patients, calls being made for several weeks after discharge. Then we have a committee that solicits jelly during the summer, a furnishing committee, and a social committee.

Money was soon demanded for various purposes, and each year one large card party and tea has been given. The first three were given in Busch Gardens, and since then they have been given at the Huntington Hotel. From those parties between $2,000 and $2,500 have been realized each year, and the membership dues of $1 a year have made our yearly average about $3,000. In addition to this amount, special individual contributions of about $2,000 were obtained for a large garden on the hospital grounds.

The money raised was largely expended for special nurses for charity cases; each year some equipment has been contributed. One year we equipped and furnished the children's ward. Some of our other activities have been: paying for anesthetics, X-rays and special drugs; paying for blood transfusions; bought 40 Fowler beds and Beauty Rest mattresses; bought 40 large pillows and 60 small ones; bought 20 bed trays; bought 12 foot stools; furnished table silver for nurses' home; furnished Christmas trees for the wards; directed surgical dressings in five units, at the Huntington Hotel, Vista del Arroyo Hotel, the Maryland Hotel, Neighborhood Church and the Presbyterian Church, with another group at the Block-Aid center for unemployed women; directed sewing on surgical gowns and other sewing; distributed home-made jellies once a week; distributed books and magazines once a week; maintained the large garden previously developed, and we have just finished putting in a concrete walk around the garden, which will enable patients to be wheeled out in their beds.

In order to hold the interest of members, a very attractive membership tea is given each spring in some private home where reports of the work are made, election of officers made, and dues collected. At various times during the early years the interest lagged between parties, and the organization had little stability. Then the plan was adopted of asking every women's organization in the city to appoint a representative to attend the monthly board meetings, serve as an "associate member" of the board and carry back any reports of interest. These representatives immediately became interested and some of them became officers of the board. Since then there has been a growing active interest in all the hospital work.

We also have organized a junior auxiliary which is steadily growing.

From a paper before 1933 convention, Western Hospital Association.

OHIO COMMITTEES

Membership: Hulda C. A. Fleer, chairman, Aultman Hospital, Canton; Charles E. Findlay, City Hospital, Springfield; Sr. M. Anastasia, Mercy Hospital, Toledo; Dr. Walter E. List, Jewish Hospital, Cincinnati.

Resolutions: Mary A. Jamieson, chairman, Columbus; Rev. Carroll H. Lewis, Christ Hospital, Cincinnati; Rev. M. F. Griffin, Cleveland.

Industrial Commission: Guy J. Clark, chairman, Cleveland Hospital Council, Cleveland; Rev. M. F. Griffin; Dr. E. R. Crew, Miami Valley Hospital, Dayton.

Legislation: B. W. Stewart, chairman, Youngstown Hospital; Dr. E. R. Crew; Frank W. Hoover, Elyria Memorial Hospital, Elyria; Guy J. Clark; A. E. Hardgrove, City Hospital, Akron.

Nominations: Dr. E. R. Crew, chairman; Dr. Frank C. Fowler, White Cross Hospital, Columbus; Mary E. Gelser, Union Hospital, Dover.

Standardized Accounting: Worth L. Howard, chairman, University Hospitals, Cleveland; Francis R. Van Buren, Children's Hospital, Cincinnati; Nellie C. Smith, Ohio Valley Hospital, Steubenville; D. A. Endres, Youngstown Hospital, Youngstown.

Why the College of Hospital Administrators?

By J. DEWEY LUTES
Superintendent, Ravenswood Hospital, Chicago

THE American College of Hospital Administrators is new only as an organization. The needs for such an institution have been discussed by hospital superintendents over a period of years. No one individual active in the organization work can therefore claim originality for the idea.

In February of this year 34 hospital executives and administrators met in Chicago to take steps toward the recognition of hospital administration as a profession. This group recognized the need for setting up standards for hospital administration in order to determine the ability of the superintendent and to foster the training of properly qualified persons to direct hospitals in the future.

The status of hospital administration has changed considerably during the past 50 years, a fact which is not difficult to understand when one remembers that the number of hospitals in this country has increased 50 times during the last half century while the population has less than doubled. Significant also has been the growth in the number of hospital beds from 35,000 to approximately one million.

Not only has the hospital grown into a billion dollar business and developing a close relationship with the community, it has also gone into the field of education, acting as a training ground for medical students, nurses, dietitians and others. Furthermore, it has enlarged its scope to include not only the cure, but also the prevention of disease.

It is evident, then, that the hospital is a highly complex organization, combining with its medical services both business responsibilities and community relationships. Its intricacies of organization and high degree of specialization have made of hospital administration an art and a science requiring special training, adequate experience, and extraordinary skill. The doctor, nurse, or person trained in other fields cannot plunge into this complex type of work without careful training and experience if he or she is to be successful.

It is certainly true that most governing bodies, medical staffs, and the general public as well, believe that the administration of a hospital is a relatively simple task, and that practically any human being should be able to superintend a hospital without having to have training and experience. Heretofore, governing bodies have had no particular designation to guide their selection of superintendents.

During the past few years there have been numerous instances in which exceptionally well trained superintendents have been replaced by men and women who have not had the slightest training. The majority of superintendents today have arrived at their goal through plunging into the work on their own responsibility and without any supervision or previous experience. It is true that some are making good, but that is due to inherent ability and the result of unguided apprenticeship during which they made many errors. There can be no doubt that much of the inefficiency and waste in hospitals today can be traced directly to inexperience of administrators.

There is a distinct tendency in medicine and surgery today to designate specific groups according to specialties. For example, the American College of Surgeons confers upon ethical surgeons of adequate training and experience the title F. A. C. S. to indicate proficiency. Likewise, the American College of Physicians awards fellowship to outstanding, capable physicians. In the specialties of eye, ear, nose, and throat, and in obstetrics and gynecology, pathology, X-ray, etc., there are various designations to indicate standing as a specialist. There is no field which requires the recognized specialist more than hospital administration.

So that hospital administration may be improved and eventually established as a profession, the American College of Hospital Administrators was permanently organized at Milwaukee, during the 1933 convention of the American Hospital Association. The credentials committee approved 70 administrators for charter membership and 11 honorary members.

To prevent any misunderstanding or wrong assumptions, the College desires to have it distinctly understood that it will not duplicate or infringe on any of the activities of the American Hospital Association; that it has a distinctly individual piece of work to do; that it has gone on record as desirous of working in close harmony and cooperation with the American Hospital Association and to strengthen and broaden the influence of that organization wherever possible. No administrator will be admitted to membership unless he or she is a member of the American Hospital Association.

As the College progresses with its work of advancing the standards of the individual administrator it is not unreasonable to suppose that the American Hospital Association will be benefited by closer cooperation and greater support from hospital administrators. It is a stimulation to the individual administrator to know that his or her labor will gain recognition and will be given a mark of distinction.

The fact that the field recognizes the purposes and needs for such an organization is indicated by payments to date of dues from more than two-thirds of the charter members. This is further demonstrated by the many letters we are receiving from superintendents in all parts of the United States and Canada.

A large number of superintendents will be admitted to membership at the next annual meeting.

Objects of College

(a) To elevate the standard of hospital administration.

(b) To establish a standard of competency for hospital administrators.

(c) To develop and promote standards of education and training for hospital administrators.

(d) To educate hospital trustees and the public to understand that the practice of hospital administration calls for special training and experience.

(e) To provide a method for conferring Fellowships in Hospital Administration on those who have done or are doing noteworthy service in the field of hospital administration.

Mr. Lutes is director-general of the A. C. H. A.

Principles Underlying Make-up and Operation of a Budget

By JOHN D. WEAVER

Credit Manager, Lancaster General Hospital, Lancaster, Pa.

IT is my desire to present very briefly the preparation of a hospital budget, what it is, what constitutes its makeup, and how it is prepared.

A budget may be defined as accounting in advance, as distinguished from accounting which follows an event. It is that branch of accounting which forecasts future operations.

Budgetary control in a hospital is:

(1) Assembling information that may have an effect on its operations during a stated ensuing period.

(2) Applying the information to forecast trends and to formulate a program, and

(3) Using the program currently for measuring operations.

Before going into some of the items that make up a budget it is necessary for a hospital to have proper organization and cooperation of department heads so that definite responsibility may be fixed. Otherwise the shifting of responsibility may prevent the proper functioning of the budget.

The items that make up a maintenance budget are divided under two heads—income and expense. A separate budget may be made up for items of worn-out equipment and new equipment, which may be called a replacement budget. This budget should be made up only after a careful study has been made for the need of replacing old and worn-out equipment and at the same time making provision for purchasing new equipment for the making of a more modern hospital.

Under the heading of income, the following items may be listed:

Income from endowments and trust funds.
Income from service
Income from county.
Income from state aid.
Cash contributions.
Miscellaneous income, and
Income from welfare organizations.

Under items of expense, the following divisions may be made:

(1) Administrative, under which may be classed administrative salaries, office supplies, postage and printing, telephone and telegraph, and miscellaneous administrative expense.

(2) Service expense, under which may be classed service salaries, that is salaries of supervisors, student nurses, anesthetists, druggist, orderlies, or anyone connected directly with the care of patients, auto and upkeep, educational expense, and miscellaneous service expense.

(3) Institutional expense, under which may be classed labor (including salaries of porters, maids, laundry, dietary and housekeeping help), fuel and light, ice, food, housekeeping supplies, laundry supplies, repairs to building, repairs to equipment, and miscellaneous institutional expense.

(4) General expense, under which is classed rent, interest, insurance, and miscellaneous general expense.

Naturally these items of income and expense may be changed and other divisions added if necessary, depending entirely upon the individual hospital. However, the above items are mentioned so that we may have an idea of the make-up of a budget.

In preparing the annual budget it is wise to begin sufficiently early to afford time for its consideration by the finance or budget committee of the hospital, so that revisions may be made if necessary and final approval given prior to the beginning of the fiscal year to which it relates, and also prior to the local welfare campaign. The forecasting of the items of income and expense should be based on the figures of years of past experience in conjunction with the outlook for the future. Income from endowments and county and state aid are fixed in most cases so it is not difficult to determine the revenue from that source. Contributions and miscellaneous income may be determined on the basis of past experience. The chief problem is to forecast the income from service. Naturally, this should be based on previous experience together with a survey of the general economic situation in the country as a whole, with special attention to the territory served by the hospital and on which it depends for its income. The health situation of the community is another important factor to take into consideration in estimating this item.

There are several kinds of expense that are fixed, such as salaries, rent, interest and insurance, so there is not much difficulty in arriving at a figure for these items. The remainder of the expense items should be based on the experience of past years, together with any immediate need, as well as the outlook of marketing conditions, namely the prospect of a high or low commodity price. The unused bed capacity is another item that plays an important part in forecasting some estimates of expense. After the figures have been set for income and expense, the amount needed to balance the budget or the difference between the total income and total expense represents the need from the local welfare federation, or the amount that is necessary for the hospital to secure through its own campaign.

After the budget has been prepared and approved, the estimates should be set up by months. With respect to financial accounting control of expense, this may be done by merely dividing by twelve the amounts of the various items for which a year's estimates have been made, or by recognizing the fact that the percentages of bed occupany are higher in some months than in others, and assigning to each month such amounts as will be proportionate to the needs of that particular month. Eliminating unusual epidemics and considering the average year to year occupancy figures by months it will be found that in some hospitals the percentage of bed occupancy is highest during the first three or four months of the year, and in some this "peak load" is highest during the summer months, and in some it fluctuates but little from month to month throughout the year.

As stated before the success of a budget, as in any kind of an organization, is greatly aided by the cooperation of all departments. The time to enlist that cooperation is when the budget estimates are being prepared, so that the department heads are made to feel that they have a definite

From a paper before Eastern Central Pennsylvania District Hospital Association, Bethlehem, Pa., October 25, 1933.

Don'ts for Your Visitors

DON'T take small children with you when visiting in the hospital; they might contract some illness.

DON'T honk motor horns or open cut-outs within the vicinity of the hospital.

DON'T make undue noise inside or outside the building.

DON'T expect to get in before, or stay after, visiting hours.

DON'T remain too long when visiting a very sick patient.

DON'T speak in a loud voice; remember you are in a hospital.

DON'T litter the halls with parcels and papers—it costs money to clean.

DON'T destroy or waste hospital property —this only adds to the deficit.

DON'T forget that most fires are caused by carelessness.

DON'T give a patient delicacies unless permitted to do so.

DON'T sit on a patient's bed—this means extra laundry.

DON'T open windows in the wards without consent of the nurse in charge.

DON'T excite the patient.

DON'T forget to be discreet.

DON'T talk of accidents you have seen.

DON'T tell all your troubles to a convalescent.

DON'T talk of other people's experiences in hospitals.

DON'T tire the patient with talking or asking questions; if the patient wishes to talk, let him talk to you.

DON'T worry a patient with troubles that may have occurred in his or her home—make the best of them, or tell someone else.

DON'T, while talking to a patient in the hospital, tell of all the operations you have experienced or heard of that might have been unsuccessful.

DON'T interfere with bandages or dressings on a patient.

DON'T forget that the nurses on duty are busy persons, so DON'T hinder them needlessly.

DON'T forget that most doctors are doing their best for the patient and are not always to blame when things seemingly go wrong.

DON'T forget to make your complaints (if any) to the hospital authorities. They are the only persons who can rectify them.

DON'T ask to see any operations.

The list of "don'ts" shown above was noted recently in Hinsdale Sanitarium and Hospital, Hinsdale, Ill., L. M. Bowen, manager. Many other hospitals could use such announcements with good effect in corridors, elevators, waiting rooms and similar places.

part in the preparation and that the final carrying out of the program rests with them.

The general budget that was explained before may be further divided into subdivisions. This plan may work out to good advantage provided the setup does not become to complex. Simplicity should be the keynote of the budget and all procedure incident to it throughout the hospital. A complex budget may reach the point where the departments are swamped with masses of figures to such an extent that the main purpose of the budget is defeated.

Above all things a budget should be flexible so that it may be changed to adjust the program to meet existing conditions as they may turn up in going through the year from month to month. One item in particular must be made flexible, namely, medical and surgical supplies. There are various reasons why flexibility should exist in this particular item. For instance, certain types of cases may be admitted to the institution that require expensive drugs and serums, and inasmuch as the prime object of a hospital is to serve, the medication orders must be carried out regardless of the setup of the budget estimate for that particular item. We cannot say that due to our budget setup we are not allowed to supply the particular medication because we will overstep our budget estimate. Therefore, there must be considerable flexibility.

When the approved budget is finally set up, it acts as a yardstick for measuring the operations of the institution financially. It is quite interesting to compare the actual figures with the estimates from month to month. In this way it enables the manager to put his finger on items that run over the estimates so that an investigation may be made to find out if there is any waste or just what the trouble might be. The comparison of the actual with the estimates shows a clear picture of the hospital operations as well as bringing about increased economies, by setting a task for the department to carry out. The right type of department head welcomes figures that show clearly and correctly whether the department has beaten "par" or not.

Taken all in all, a simple budget that has been carefully prepared and set up from month to month is a distinct asset to the hospital head and the board of directors because they can see clearly in what direction the hospital is headed and what the particular monthly financing requirements may be.

A. C. S. Conference Held in Chicago

Whether the attractions of A Century of Progress proved too great to permit time for registration, or whether the closeness and nearness of the A. H. A. convention at Milwaukee followed by the three weeks' institute at the University of Chicago, made it impossible for more visitors to remain over, the fact is that attendance at the hospital conference of the annual clinical congress of the American College of Surgeons at Chicago last month was below average, although the registration of surgeons and the admissions to fellowship were in keeping with the best attended affairs in past years.

Dr. M. T. MacEachern, director of hospital activities, prepared his usual comprehensive and well planned program for the hospital visitors, opening with the hospital standardization report meeting at which the featured talks concerned the results of the latest survey of the College. Economics and finances occupied a prominent place in all the discussions, alongside with technical and professional problems. Two afternoons were spent in administrative clinics in St. Luke's and St. Elizabeth's Hospitals, and the final afternoon offered separate clinics in numerous features of management and operation in more than a dozen institutions. There was a joint session with the Association of Record Librarians of North America on record problems, followed by a round table on this subject.

The "free for all" round table, at which were discussed questions submitted by Dr. MacEachern as typical of the most interesting and pertinent which were asked by hospitals in recent months, was another feature, this being conducted jointly by Robert Jolly, Memorial Hospital, Houston, Tex., and by Dr. R. C. Buerki, University of Wisconsin Hospital, Madison. Beginning with this issue, Mr. Jolly will answer the 100 questions which were the basis of this round table.

The program for the different sessions, as presented in the last issue, was followed with few changes.

The annual community health meeting under the auspices of the College was held at the Chicago Stadium on Wednesday night of convention week and attracted a crowd of more than 10,000.

The annual list of hospitals approved by the College was published in HOSPITAL MANAGEMENT last month.

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Support the A. H. A. Plan For Legislative Action

At a recent meeting of the board of trustees of the American Hospital Association, a considerable amount of time was spent discussing ways and means of obtaining a representative of the hospital field on a full time basis in Washington in order to explain to Congressmen and government officials the problems, financial and other, with which hospitals must constantly contend.

HOSPITAL MANAGEMENT urges every hospital in the United States to support this plan of the American Hospital Association and to contribute generously to the fund that will make this representation possible. It goes without saying that a man to represent the hospital field must have certain qualifications and must be guided by ethical principles in his work, but if such a man is found, every hospital ought to make possible his retention as a representative of the A. H. A. and therefore of the hospital field in this country.

It was stated unofficially that hospitals belonging to the A. H. A. were to be asked to contribute at least five dollars toward the fund to make possible the employment of a capable representative in Washington. This is an insignificant sum for any hospital to give, since in all probability the hospital representative will be able to show to Congress and national officials a picture of hospitals as essential institutions, meriting leniency, if not exemption, in the application of tax laws.

Hospitals in a number of communities and in some states already realize that taxing bodies, in their efforts to find new sources of taxation to offset losses due to inability of individuals to pay their tax bills, are eyeing educational and benevolent institutions. Until recently legislators, local and state as well as national, recognized the charitable character of non-profit hospitals and exempted them from taxation. But the need for funds for the maintenance of government agencies and the application of new taxes of various kinds have brought about some situations wherein hospitals are expected, in some instances, to pay taxes in spite of the fact that hospitals, generally speaking, are in the worst financial condition, perhaps, in their history. The general economic state of the public has reduced the number of patients able to make payment for hospital service, even in part, and has materially increased the number that must depend on charity.

Another important consideration in regard to legislation and taxation affecting hospitals is that the example of the national government may be followed by local and state authorities. For this reason it is all the more important to have a spokesman for the hospital field in Washington who can speak authoritatively and effectively for hospitals.

So HOSPITAL MANAGEMENT urges every hospital to do its part in aiding the American Hospital Association to employ a competent representative at Washington.

A. H. A. to Hold Another Institute for Executives

Announcement that the American Hospital Association is definitely planning another institute of hospital administration will be cordially welcomed by the entire field. While details are yet to be worked out, it is likely that Chicago will be the scene of the course because of its location and also because of the variety of hospital experience available in its numerous institutions. Then again it is likely that greater use will be made of the headquarters of the various national associations located in Chicago, because these associations are steadily exercising a greater influence on hospital management and a knowledge of their programs is essential to the proper direction of an institution.

Those progressive individuals, nearly 200 in number, who participated in the first institute can do much to make the 1934 course even more successful by giving to the A. H. A. and to the committee in charge full and frank criticisms and suggestions concerning the course held this fall. A number of most helpful suggestions, incidentally, were contained in the comments made by the students for publication in HOSPITAL MANAGEMENT.

One factor that ought to help improve the institute to a considerable degree (and this is said without criticism of the most successful institute of this year) is that the committee has nearly a year in which to work out details, compared with little more than a month for the first institute. The committee acknowledges that there were a number of rough edges to the first institute, but practically

all of them were due to the fact that there was no way to gauge the approximate number of registrants, and the final registration far exceeded expectations. With a longer period for preparation, a "dead line" for registration may be set considerably in advance of the opening of the institute and this will help to eliminate inconveniences and to increase the effectiveness of the program.

But the most important factor in the further improvement of the 1934 institute will be the suggestions and expressed wishes of those who want to register. After all, just as the patient is the most important person in a hospital, so a student is the most important person in an institute, and the wishes and needs of the student in regard to instruction and field studies ought to be the foundation of the coming program.

Mr. Jolly to Answer More A. C. S. Round Table Questions

It is with a great deal of pleasure that HOSPITAL MANAGEMENT calls attention to the first group of a second series of 100 questions that are answered in this issue by Robert Jolly, superintendent, Memorial Hospital, Houston, Tex. The remaining questions and answers will appear in succeeding issues until the entire series offered by the American College of Surgeons as typical and most interesting questions received from hospitals approved or seeking approval during the past year, is completed.

HOSPITAL MANAGEMENT published Mr. Jolly's answers to the best 100 questions, as selected by Dr. MacEachern, and presented to the field through the round tables conducted by the American College of Surgeons during 1932-33, and received so many evidences of interest in these questions that we prevailed upon Mr. Jolly to conduct another round table in our columns using the new set of questions as the basis.

As those who are familiar with the meetings of the American College of Surgeons are aware—sectional as well as national meetings—Mr. Jolly several years ago was selected by Dr. MacEachern to conduct many of these round tables, and his ability to put the audience at ease and to extract detailed, interesting answers made him a great favorite. With his ever-present humor and his ready answers, Mr. Jolly is an administrator of a high type and of the most practical kind, and in answering the questions beginning in this issue he draws not only upon his remembrance of the meetings at which the questions were discussed, but also upon his own valuable and successful experience. Readers are urged to write either to Mr. Jolly or to HOSPITAL MANAGEMENT for an amplification of answers to any of the questions, or for a further application of the principles, etc., to a given situation.

It is to be noted that the answers of Mr. Jolly are both brief and direct. If the answer is "No" he says "No." If he doesn't know the answer he admits that he doesn't. He has purposely condensed the answers to save time of readers and to permit more answers being given on the page.

Watch for Mr. Jolly's answers to the 100 A. C. S. questions in each issue, beginning with this number, and don't forget that he will be glad to amplify or discuss any question further if you are interested.

A. H. A. Publicity Program Makes Progress in Field

The efforts of the American Hospital Association through its committee on public education headed by Dr. MacEachern are gradually awakening in the minds of more and more hospital superintendents the necessity for a well defined program of community education. The frequent reference to "The Evansville plan," as originated and developed by A. G. Hahn, Deaconess Hospital, with the cooperation of St. Mary's and Walborn-Walker Hospitals of that city, and the demonstration by Mr. Hahn and by Mrs. Hahn of some of the details of the plan at sectional and national meetings have helped to convince other superintendents that an educational program is not expensive or impossible, and that it does produce results.

One of the latest hospitals to begin a program of this kind is Brokaw Hospital, Normal, Ill. Addresses at stated intervals to which the public is invited is a feature of this plan, and the fact that a schedule of educational talks has been worked out will undoubtedly add materially to the effectiveness of this program. Miss Knapp is to be congratulated upon her inauguration of this program which undoubtedly will gradually increase in scope as results justify.

One reason why so many hospitals fail to attempt an educational program is that they feel that such a program must be comprehensive and involved and that experts must employed. Evansville has demonstrated that such requirements are not necessary, and Normal is showing that a program may be begun with one central feature—a series of public talks about different phases of hospital service.

Miss Knapp is to be congratulated upon her start in this program, particularly since she has included among the speakers Mr. and Mrs. Hahn, who are to put on the same presentation of features of the Evansville plan that was so well received in the Illinois-Indiana-Wisconsin conference and at the A. H. A. meeting.

Which hospital or hospital council will be next to take up this most effective and most necessary type of educational work?

"Few Standards of Hospital Practices" Is a Fallacy

Occasionally one hears an executive criticize some organization or agency for its failure to establish standards for certain practices and sometimes the critics will even hazard the statement that there are practically no standards or accepted practices in the hospital administrative field. He speaks of administrative activities, not of professional service, for, of course, the work of the various associations in the professional fields is widely known.

But the average critic who laments the absence of standards and approved methods and practices in the administrative field would be greatly surprised to find out just how many standards and practices recommended by different associations there are. As a matter of fact, most complaints about scarcity or absence of standards come from comparatively newcomers, but even executives of long standing who do not attend conventions and who are not familiar with the fine work of committees and special bodies do not appreciate how numerous and how practical the recommendations are.

A recent study disclosed that something like a score of national associations, some of them fifty years old, have made recommendations to assist in the solution of hospital problems or for the carrying on of routine hospital activities; a great amount of valuable work has been done, which is available to any interested person for the asking.

Most of the people who do not know about these recommendations, resolutions, committee findings, etc., either are newcomers to the field or people who have not had an opportunity to contact the various organizations as closely as they should have done. For the truth is that a great quantity of valuable information and practical advice is readily available to most hospitals, if they will only look for it.

Important Factors in Oversupply of Laboratory Technicians

Inadequate Training Cited as Chief Reason for Large Number of Unemployed Workers in This Field; Meaning of Registered Technician and How Registration Is Accomplished

By ROY KRACKE, M. D.
Emory University, Ga.

IN this discussion the term "laboratory technician" refers to that individual who is engaged in the practice of medical laboratory work, including such procedures that are usually carried out in the laboratories of hospitals, state boards of health, university medical departments and in the offices of private physicians, and clinics.

The duties of a laboratory technician are dependent upon the type of laboratory in which they are employed, and are, of course, quite variable. Thus the technician in the state board of health may carry out only bacteriological or serological procedures, whereas the technician in the average hospital laboratory is required to execute a much wider range of laboratory tests, including work in blood, urine, chemistry, hematology, parasitology, bacteriology, examination of exudates, serology, etc. It obviously follows, that a technician who works in the highly departmentalized laboratory of a large institution is apt to render a specialized type of service and may know very little concerning the other common laboratory procedures. The laboratory worker in small hospitals and doctor's offices is supposed to carry out a more diversified range of work and, therefore, be not so highly skilled in any particular branch. These are some of the important considerations in the training of a laboratory worker.

There are today in the United States about 7,000 individuals engaged in laboratory work. At this time presumably one-third of these are unemployed. This situation has been brought about chiefly by the economic depression, and also by the fact that in the past ten years an unusual number of young women have gone into this field as their chosen vocation. Even should there be a return of prosperity, it is doubtful if there would be a sufficient number of places for those laboratory workers that have already been supposedly trained in this field. Of this 7,000 technicians it is estimated that approximately half of this number are not sufficiently trained to be classified as competent workers.

This situation has resulted, of course, in a lessened remuneration for those who are now engaged in this work. The average salary paid the competent laboratory worker today does not exceed $100 per month. In some instances, of course, it is above that figure and in many it is below. Some of our larger universities have a standard scale of $75 per month for competent laboratory workers. It is not a vocation, therefore, in which one may expect to be amply financially rewarded.

For this situation there are other compensations: the chief one being the daily variety of work and the interest and enthusiasm that one is able to derive from it. In my own experience, I have trained several young women who are college graduates and former school teachers, and who received far more remuneration from teaching school than from their work as a laboratory technician, yet almost without exception, it is extremely doubtful if one of them would return to their former vocation of teaching.

The young woman who goes into laboratory work today should be, if possible, a college graduate or at least should have had college work. One of the reasons that we have 7,000 laboratory workers in the United States has been because of the large number of young women who have gone into this work, who are high school graduates, and in many instances have not completed high school. Obviously, the more education a young woman has the more competent she will eventually become in the laboratory field.

Also the present choatic situation of laboratory workers has been due in large part to the unregulated methods of training these workers. There has been no standardization of education in this field. Any one who wishes may become a laboratory technician under our past and present system. For example, if a physician desires, he may select some young girl who has not even graduated from high school, who may be a relative or a daughter of a good friend, place her in his office and then give her a few meager instructions concerning the simpler laboratory procedures and finally turn her out as a so-called laboratory technician. A large percentage of those who profess to be laboratory technicians were haphazardly trained in this manner. The physicians themselves, therefore, have contributed largely to the present status of the laboratory technician. The well trained worker, then, is forced to compete with the type trained in the manner just described.

Also, many of our technicians have been trained in an equally uncertain manner in the hundreds of hospital laboratories. It is a common practice for a director of a hospital laboratory, who may or may not be a pathologist, to supplement his employed staff of technicians with one or more young women who are said to be in the process of training. After these young women have spent perhaps only a few weeks in the laboratory they are then designated and stated to be laboratory technicians. The director oftentimes has little interest in this matter except to provide additional help in his laboratory without paying for it. In many instances hospitals charge their patients full fees for blood counts, sputum and urine examinations carried out by

A list of approved schools for training laboratory technicians was published on page 60 of the October issue of "Hospital Management."

Member, Board of Registry, American Society of Clinical Pathologists. Professor of Bacteriology and Pathology, Emory University School of Medicine.

young women in the process of training with only a few weeks' experience. Therefore, the pathologists themselves have contributed to the choatic situation of laboratory workers and are equally at fault with the rank and file of physicians in producing this plethora of untrained laboratory workers.

Similar situations have existed, and do exist, in many state board of health laboratories. The average state board of health laboratory is concerned chiefly, if not solely, with laboratory work of only a public health nature. Young women are taken as students in these laboratories and perhaps spend several weeks in each of the various departments, and, even assuming that they become well trained in these particular departments, they still remain woefully deficient in the other forms of clinical laboratory work. Even so, these young women are then turned out as qualified technicians, and many of them assume responsible positions in clinical laboratories of various types.

Furthermore, a large number of our technicians have received their training in so-called laboratory training schools, which, during the recent period of prosperity, have sprung up like mushrooms over the United States. Some of these schools were organized mainly by individuals who were not concerned in turning out a well trained laboratory technician, but who were mainly concerned in obtaining large numbers of students; charging exorbitant fees; and then giving a few weeks of a rather questionable type of instruction; and finally turning out these young women in large classes to be thrown out on the public as qualified laboratory workers. Some of these schools can be designated properly as commercial training schools, organized purely for profit, with little regard of the type of worker that is turned out. They are extremely lax in their entrance requirements and many of them will accept as a student almost any person who may apply.

Fortunately, because of the educational program of various medical agencies who are interested in stamping out this evil, many of these schools have disappeared, but a few of them still continue to function, and it is hoped that their extinction will soon come about.

Also there is an occasional school that is operated by some official medical agency, such, for example, as a state board of health. It seems that the primary function of a state board of health is to care for the welfare of the people and not to engage in training school activities for laboratory workers. It is obvious that such an institution does not have proper clinical facilities to turn out well rounded laboratory workers, and there seems to be little excuse for the existence of these schools as such.

Finally a small percentage of our laboratory workers have been trained in university medical centers, and this represents the ideal training of today. The university in the past has not concerned itself with this type of education to the extent that it should. We note today, however, an increasing interest on the part of the universities to take over this phase of medical education. The training of the competent laboratory worker of tomorrow should lie in the hands of the university, just as the training of the competent physician is now carried out by our best universities. It can not be denied that the function of the laboratory worker is an important one. Important diagnoses oftentimes rest upon their findings and this type of medical service becomes, therefore, a very important one in the diagnosis and treatment of disease, and the training of people in such work demands university recognition of the problem.

It is a deplorable fact that the education of nurses in this country is far more standardized, and far more rigidly controlled than has been the education of our laboratory technicians. It would seem that the ideal method of training the laboratory technician of tomorrow would be to offer a definite schedule of instruction in the medical schools and in their associated hospitals; entrance requirements, of course, should be high. The work should cover a period of at least twelve months, and preferably much longer than that. Probably the ideal scheme of instruction would be a four year college course, including the important fundamental subjects as chemistry, biology, physics, mathematics, languages, etc., followed by more specialized instruction in bacteriology, parasitology, hematology, clinical chemistry, tissue technique, serology, etc., all of this extending over a four year period with the granting of a bachelor's degree upon its completion. A few universities in this country have now instituted such a system of training.

Obviously this radical change in laboratory training can not come about over night, but the ideal must be gradually attained, possibly over a period of years, just as medical education was, at one time, put on the firm, established basis on which it now rests.

It is with this end in view that the American Society of Clinical Pathologists, an organization of nearly 500 leading pathologists in this country, have established what is known as the Board of Registry, whose chief purpose it is to examine and register those laboratory technicians whose education, training and experience justify their classification as competent workers. It is also the purpose of the Board of Registry to attempt to eliminate the so-called commercial training schools; and finally to approve and classify the various schools and laboratories that are capable of adequately training competent laboratory workers. This work has gone on now for several years and, at this time, over 2,000 laboratory technicians have been approved as qualified by the Board of Registry. A list of approximately 40 schools and laboratories have been approved as being capable of training laboratory workers. In this connection I quote from the September, 1933, bulletin of the Registry of Technicians of the American Society of Clinical Pathologists.

"With the ever increasing employment of laboratory methods in the practice of medicine, the need for systematically trained assistants has become a vitally important question. Very frequently the diagnosis of disease rests on the results of the test performed by the laboratory technician. The findings seriously affect the weal and woe of a human being and are often fraught with the performance of a major surgical operation. The moral integrity and technical ability of the laboratory worker must therefore be of the highest possible standards and in keeping with the safeguards laid down by law for physicians, pharmacists and nurses. With this object in view the American Society of Clinical Pathologists, an organization of scientific physicians, engaged in the specialty of performing and interpreting to the medical profession laboratory methods in the diagnosis and treatment of disease, established in 1928, a Board of Registry to prepare proper standards for the qualification of laboratory technicians and to investigate the schools and methods of their training. As a result of the activity of this Board, certificates of competence have been issued to those workers who were found to possess the necessary qualifications and approval given to those schools that complied with the minimum requirements laid down by the Board."

"The Registry of Technicians of the American Society of Clinical Pathologists has received the endorsement of the American Medical Association, the American

College of Surgeons, and the American Hospital Association, who are wholeheartedly co-operating in our endeavor to elevate the educational and scientific level of the laboratory technicians of the United States and Canada. Hospital administrators, clinical pathologists, and physicians in general are now requiring the possession of a certificate from our Registry in engaging new laboratory personnel. Over 2,100 technicians are now enrolled under our auspices and their names inscribed in our Roster. A full list of our registrants classified both alphabetically and geographically is issued annually.

"It is the aim of the Registry to eventually enroll under our banner all competent laboratory technicians who possess the necessary qualifications, and thereby insure the best of service in the diagnosis of disease by modern laboratory methods."

Due to the activities of the Board of Registry in the elimination from the laboratory field of those workers who are uneducated and ill-trained, it is hoped that the time will eventually come when a premium will be placed on the services of the competent worker who has been well trained under proper conditions. Therefore, it is believed that the prospects for the competent worker are good for the future.

The Board of Registry today is recognized as the accrediting agency for the competence of laboratory workers and registration by the Board places a stamp of approval on the worker who is registered.

A program is now being launched with the co-operation of the American Hospital Association, the Council on Medical Education and Hospitals of the American Medical Association, and the American College of Surgeons in which these hospital accrediting agencies are now directing specific inquiries to their accredited hospitals in which they wish to know the status of their laboratory technicians. They wish to know if the technician is registered, and if not, why she is not registered.

It is hoped that the time is not far distant when the hospital accrediting agencies will demand registration of laboratory workers. Such a program then will result in the weeding out of the incompetents and finally the laboratory services in our better institutions will be carried out by certified, competent workers.

The Board of Registry earnestly solicits the co-operation of hospital executives, physicians, and laboratory directors in their efforts to raise the standards of our laboratory technicians. Therefore, hospital administrators are urged to have their technicians registered with the Board. Requirements and procedure are stated below:

REQUIREMENTS

"Applicants for certificates must have graduated from an accredited high school or have received an education equivalent thereto. In addition, they must have taken a year's college course including chemistry and biology or an equivalent thereof such as graduation from an approved training school for nurses, or credits in allied subjects in basic sciences, which, in the opinion of the Board, are of equal value to the technician. Lastly, they must have had full twelve month's instuction in an approved training school for technicians or an apprenticeship for at least a year under a qualified clinical pathologist.

"A laboratory worker who fails to fulfill the above requirements and who received his or her training prior to 1932 and whose technical qualifications are vouched for by at least three reputable physicians (at least one of whom shall be a recognized clinical pathologist) may, by action of the Board, be considered eligible."

PROCEDURE

"Candidates shall properly fill out the formal application blank of the Registry and file same with the Registrar.

"Upon receipt of application, the Registrar shall conduct a preliminary investigation of each applicant and the result shall be filed with the application.

"If found eligible, applicants to the Registry must then pass an examination conducted by a member of the American Society of Clinical Pathologists practicing in the locality in which the applicant resides. This examination will comprise:

a. An oral and practical test, counting fifty per cent,
b. Written test, twenty-five per cent,
c. Personal and psychological attributes, twenty-five per cent.

"The fee for registration is ten dollars and is not returnable in case of failure. The applicant may, after the lapse of six months, be given the privilege of another examination without additional charge.

"A certificate of registration will be issued to all applicants accepted by the Registry.

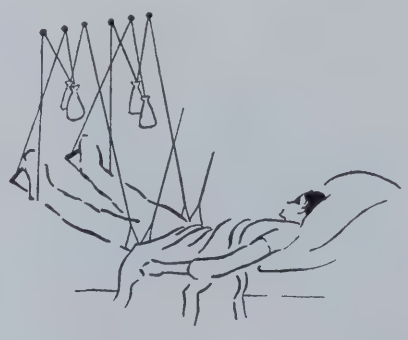
"Annual renewal of the certificate is required, for which a fee of one dollar is charged. If certificate holders do not renew their registration after three notices have been sent them, their names may be dropped from the roster. The time may be extended to those who are unemployed or ill.

"A certificate may be revoked at any time for cause by order of the Board. A hearing may be granted on request."

For further information address the Registry of Technicians, American Society of Clinical Pathologists, 234 Metropolitan Building, Denver, Colorado.

Comments From The Editor

The author's criticism of low-grade schools and of inadequately prepared laboratory technicians is, of course, not to be applied universally, "Hospital Management" believes. In other words, there are undoubtedly some competent technicians who have been qualified by the various types of schools mentioned, although, generally speaking, as the author points out, some types of schools cannot hope to offer the training and experience that those of other types offer. These comments are interjected to emphasize the fact that while low-grade schools have contributed to the oversupply of laboratory technicians, not all schools are low grade.



RESIDENCE HALLS

Mary De Garmo Bryan, former president of the American Dietetic Association, now in the department of institution management, Teachers College, Columbia University, is co-author with Etta H. Handy, director of dormitories, Lawrence College, of "Furnishings and Equipment for Residence Halls," which should be of particular interest to those concerned with the operation of residences for student nurses or for hospital personnel. The booklet is a publication of Teachers College and is of the most practical sort, dealing with interior finish and fixtures, general furnishings and equipment, food service furnishings and equipment, furnishings for living and social rooms, and with laundry equipment and service spaces. A large number of people in the field aided in the preparation of this book, including 56 managers of residence halls, and six college treasurers, as well as graduate students, and manufacturers of furnishings and equipment. The booklet contains lists of furnishings and equipment for halls of different capacities, with costs estimated as of summer, 1932, in different sections of the country. "Furnishings and Equipment for Residence Halls" may be obtained from bureau of publications, Teachers College, Columbia University, New York City.

HONOR SCHOOL FOUNDER

A tablet honoring the memory of Sister Rose Vincent Toomey, founder of the training school for nurses at St. Mary's Hospital, Passaic, N. J., recently was unveiled in the hospital chapel. Sister Rose established the school thirty-three years ago. The Rev. E. F. Garesche, S. J., president of the Catholic Medical Mission Board, gave the address at the dedication, praising the work of Sister Rose and commenting that her work was typical of that of other pioneer nurses whose efforts in the early days have made possible the splendid institutions that exist today.

This photograph of annual banquet shows the splendid attendance at Ontario Hospital Association convention in Toronto.

Ontario Meetings Prove a Huge Success

MEETING conjointly with the Ontario Hospital Association at Toronto October 25-27 were the Ontario Conference of the Catholic Hospital Association, the Ontario United Hospital Aids Association, and the Canadian Occupational Therapy Association.

The Catholic group had a registration of over 200 at this, their second annual convention. Many fine papers were presented and Rev. A. M. Schwitalla, S. J., president, Catholic Hospital Association, was present and offered many helpful suggestions in his round table.

Delegates from all over Ontario attended the sessions of the hospital aids and the highlight of their convention was the reception given at Government House at which the president, Mrs. O. W. Rhynas, received with the Lieutenant Governor and Mrs. Bruce.

Addressing the occupational therapy meeting Fraser Armstrong, president of the Ontario Hospital Association, told the delegates that hospital executives are recognizing more and more the value of occupational therapy. Dr. Herbert Hyland of the Toronto General Hospital, speaking of the treatment of psycho-neurotic patients, said that therapy is an ancient art known in Egypt as early as 172 A. D. when sufferers from melancholia, who came to worship at the shrine of Saturn were given pleasure trips on the Nile in gaily painted boats, thus adding diversion to devotion. Many speakers stressed the necessity of play organized for mental patients and the advantage of playing on the patient's love of commendation.

With an attendance larger than ever before, the tenth annual convention of the Ontario Hospital Association was outstanding.

The following are the new officers: Hon. pres., F. D. Reville, Brantford; hon. vice-pres., R. Fraser Armstrong, Kingston; pres., Brig.-Gen. C. M. Nelles, C. M. G., Niagara-on-the-Lake; pres. elect, Dr. D. M. Robertson, Ottawa; first vice- pres., Rev. Georges G. Verrault, O. M. I., Ottawa; second vice-pres., Dr. W. J. Dobbie, Weston; hon. sec.-treas., Dr. Fred W. Routley, Toronto; sec., Miss Dorothy Dart; directors, H. W. Ackerman, H. H. Browne, R. H. Cameron, Miss P. Campbell, C. J. Decker, Dr. J. H. Holbrook, J. Clark Keith, Dr. W. Langrill, T. J. Maher, William Mitchell, Miss H. Meiklejohn, Dr. John Ferguson, Miss M. McKee, Hugh Nickle, Rev. Sr. St. Josaphat, Mrs. O. W. Rhynas, A. E. Silverwood, G. Sutherland, A. J. Swanson, Rev. Sr. M. Vincentia, V. Williams, D. L. White, Dr. H. M. Yelland, and H. A. Rowland.

The convention opened with a welcome from Mayor Stewart, after which the report of the secretary-treasurer, Dr. F. W. Routley, was given. The Hon. Dr. J. M. Robb, Minister of Health for Ontario, paid tribute to the medical and nursing professions in their efforts during this time of stress.

The Hon. Dr. H. A. Bruce, lieutenant governor of Ontario, addressed the luncheon the first day, bringing to attention the need for convalescent facilities.

The first afternoon session was devoted to tuberculosis. Dr. N. S. Shenstone, Toronto, reviewed the progress in the treatment of pulmonary tuberculosis and with lantern slides showed the value of phrenicotomy, pneumothorax and thoracoplasty. Rev. Sister M. Gonzaga, director, school of nursing, St. Joseph's Hospital, Peterborough, in a paper on the duties of a nurse in the prevention and treatment of tuberculosis mentioned the need of better education and said that the public health nurse especially should be in a position to give reliable information in simple language.

R. E. Burns, C. A., and R. Fraser Armstrong demonstrated a system of bookkeeping which has proved very satisfactory in the Kingston General Hospital.

Dr. Helen MacMurchy, chief of the department of child welfare, Ottawa, advocated hospital care for maternity patients because this ensures good rest and safety for the mother. In commenting, Mr. Armstrong mentioned that his hospital does everything to encourage the maternity patient to remain beyond the 12-day period for the much needed rest and in the case of private patients offers them each additional day at $1.75 as an inducement.

The problem of graduate versus undergraduate nursing service was discussed by Miss A. Cleaver, superintendent, Galt General Hospital. Although the hospital has saved very little during the past few years under the new system, it does show a distinct saving in the dietary department and in surgical supplies and drugs and looks forward to successful operation of this new system next year when the last girl will have been graduated from the nursing school.

Dr. Malcolm MacEeachern's paper on "How Are the Hospitals Meeting Present Day Conditions?" referred to the necessity of drastic economies at present, but said it must be kept in mind that it is better to have a financial deficit than a service deficit. He offered ten suggestions among which were economies in the dietary department, personnel, and a combination of service wherever possible.

A short report of the meeting of the Canadian Hospital Council in Winnipeg was presented by Dr. Harvey Agnew.

The first paper Thursday afternoon was presented by W. J. Dunlop, director, university extension and publicity, University of Toronto, who emphasized the value of occupational therapy and said that results could be gauged not by exhibit of articles made, but by patients cured. He outlined the course given at Toronto University and showed the necessity of proper training.

In his paper, "Cooperation Between a Sanatorium and the Health Services of Two Counties," Dr. Shaver, superintendent of the Niagara Peninsula Sanatorium, St. Catharines, reviewed the excellent service contributed by this sanatorium to the health of the community.

There was much discussion at the round table conducted by Dr. MacEachern.

After the annual banquet the guests listened to Dr. N. W. Faxon, president, American Hospital Association, who stressed the necessity of the community hospital enlarging its scope to include preventive work. An address by Norman Sommerville, K. C., chairman of the Canadian Red Cross Society, and the presidential address of Mr. Armstrong were other features of the banquet.

The Friday sessions included committee reports, papers by Dr. C. Brink, department of health, on "Diagnostic Chest Clinics in Relation to General Hospitals," and by Dr. W. J. Dobbie, Western Sanatorium on "Free Services Rendered by Hospitals to Other Organizations."

Internships in hospitals for nurses similar to those for graduates in medicine were advised by Dr. MacEachern before the nurses' section and this same idea was brought out in the paper by Miss H. Meiklejohn, superintendent of the Women's College Hospital, Toronto.

There has been on appreciable reduction in membership in the association and Dr. Routley, in his closing remarks, expressed a desire that the convention in 1934 would be even bigger and better than the one just closing.—R. T.

Effective Educational Program Carried on by Evansville Hospitals

"THE Evansville plan" of educating the community to the value and essential character of hospital service has attracted widespread attention in the field, and has been commended by the American Hospital Association committee devoted to public education of which Dr. M. T. MacEachern is chairman.

Under the auspices of the Evansville Hospital Council, consisting of the Deaconess Hospital, Albert G. Hahn, business manager; St. Mary's Hospital, Sister Dolores, superintendent, and Welborn-Walker Hospital, Dr. J. Y. Welborn, medical director, various leaders in the hospital field have been brought to Evansville to speak before different clubs, schools and other gatherings, as well as over Radio Station WGBF. This feature of the educational work of the Council has been carried on for more than a year, and among the speakers who have appeared are Dr. MacEachern, Robert Jolly, Memorial Hospital, Houston, Tex., president-elect of the American Hospital Association; Charles A. Wordell, St. Luke's Hospital, Chicago, president, American College of Hospital Administrators; John A. McNamara, former executive editor, Modern Hospital, and Matthew O. Foley, editorial director, HOSPITAL MANAGEMENT.

As many as nine engagements were made for the visiting speakers as the program of important contacts was being worked out, but recently the day's schedule has been reduced to six appearances. A recent schedule called for talks before the students of the New Harmony, Ind., High School at 10 a. m., before a joint luncheon of the Optimist Club and Junior Chamber of Commerce at noon, before the Evansville Hospital Council at 2 p. m., at a dinner at Deaconess Hospital at 6, and over station WGBF at 3 p. m. and at 8 p. m.

Albert G. Hahn, business manager, Deaconess Hospital, is the originator and prime mover of the Evansville plan, and he carries out his ideas of hospital educational activity in numerous ways which have been frequently commended by Dr. MacEachern and others familiar with the details. A monthly bulletin, a monthly "house organ" for personnel, posters in different departments of the hospital, talks before churches, clubs and various other groups by representatives of the hospital are just a few of the activities which Deaconess Hospital carries on.

The Council's program of out-of-town speakers results in contact with the leading citizens of the community at frequent intervals, the schedule calling for talks before all the influential and active clubs at least once a year. Mr. Hahn's close relationship with the press adds materially to the educational value of the talks, for the remarks are reported with accuracy and in considerable detail, thus giving the hospitals of the community not only the advantage of an effective story told to the club members, but an intelligent and prominently displayed report of the talk in the columns of the newspapers.

Deaconess Hospital also places at the disposal of the Evansville Hospital Council's educational program the facilities of Radio Station WGBF, which has a microphone in the attractive solarium of the hospital. Deaconess Hospital broadcasts a sunshine hour five afternoons a week and also sponsors a monthly health education lecture over this station. Both the time of the sunshine hour and of the health education hour is placed at the disposal of visiting speakers who come to Evansville for the Council programs.

In discussing the success of the Deaconess Hospital's part in the Evansville plan of public education recently, Mr. Hahn pointed out that the foundation for such a program must rest on an interested and cooperative board of trustees and medical staff, and he gave full credit to the trustees and doctors for their encouragement and active support of the program.

Every Hospital Library Should Have "The Joy of Living"

THE JOY OF LIVING, by Dr. Franklin H. Martin, director-general, American College of Surgeons. Two volumes, published by Doubleday, Doran, New York, $7.

Here is an autobiography of unusual importance to hospital trustees and executives as well as to physicians, surgeons and medical men generally. To hospital trustees and executives its importance lies in the fact that it is the life history of the man who founded the hospital standardization movement as well as the American College of Surgeons, and for the younger medical men of today it is important as an absorbing story of what the medical student and the practitioner of not so many years ago had to contend with in search for knowledge and in the actual practice of medicine.

The hospital, particularly the approved hospital, which does not have "The Joy of Living" in its medical library must answer for a great deal, for this work takes the reader into the medical schools of a bygone age and introduces them to figures who have had much to do with the wonderful progress medicine has made in the last half century.

The success achieved by the American College of Surgeons is no cause for wonderment to the person who becomes acquainted with the imagination, resourcefulness, persistence, determination and courage of Franklin Martin, as revealed in the first volume of the autobiography. Dr. Martin possesses strength of character and determination to an unusual degree, a combination of other talents, and above all, a mind for practical things; he had already achieved outstanding success as a specialist and medical educator before he retired from active practice to go into the surgical publishing field in order to provide for surgeons a journal of the type that he knew they wanted and needed. From the almost immediately successful "Surgery, Gynecology and Obstetrics" came the idea of giving the surgeons an opportunity to see surgical demonstrations and technique rather than merely read about them, and with that came the first clinical congress. It was another great success; so great, in fact, that it suggested the necessity of establishing standards for good surgery. The American College of Surgeons was the result.

This reviewer has only one criticism of "The Joy of Living" and that is that Dr. Martin devoted so little space to another of his monumental successes, the development of the hospital standardization program. It is to be sincerely hoped, however, that Dr. Martin will find time to do as he intimates, namely, to write in detail the history of this all-important hospital movement, in a monograph or brochure, if not in a standard volume. However, there is so much of interest and of historical value for hospital people and medical men in "The Joy of Living" that, as stated, every hospital ought to have a copy for its trustees, staff and personnel.

"The Joy of Living" is written with imagination, humor and with a memory for detail and incident that is photographic in its clearness. Even a person unfamiliar with hospitals and medicine will find this autobiography absorbing.

The author devotes the second volume to his experiences in the world war as a member of the Council of National Defense. In this volume world figures of the war years come and go and are presented as human beings, with intimate notes of their reasons for making important decisions and of their reactions in crises.

All in all, Dr. Martin has made a magnificent contribution to hospital and medical history, and to national history, in his autobiography.—M. O. F.

W. Va. Group Plans

(*Continued from Page* 28)

physicians and interns at the disposal of your personal physician. Your own doctor determines when you are to be dismissed from the hospital.

7. All needed operating room service.
8. All needed anesthetics.
9. Three X-ray pictures to one illness or injury.
10. All needed patholoical laboratory service of every kind, as indicated and ordered by your doctor during your hospitalization, including blood count, blood chemistry, urinalysis, blood typing, gross and microscopic examination of all surgical sections, etc.
11. Routine medicines.
12. Routine surgical dressings.

13. Hypodermics.
14. First aid and emergency treatment, at the direction of your physician.
15. Surgical binders.
16. Casts and operating room supplies.
17. A special hospital allowance of $5 a day for a period of 10 days in case of emergency while traveling outside the area served by member hospitals of this Service.
18. The benefits of this plan are effective immediately in the event of accident, and 15 days from date of application for sickness except as set out below:

Hospitalization will be provided six months from date of application for tonsil and adenoid cases; conditions existing at the time of applying for membership; chronic and incurable cases, and diseases or ailments peculiar to women.

Hospital Service, Inc., has no part in the selection of your own doctor other than that he be acceptable to your chosen hospital; nor is there any interference with the friendly personal relationship that should exist between you and your own personal physician. The plan does not include your physician's or surgeon's bill; nor the services of special nurses and their board; nor vaccines, serums, orthopedic appliances, etc.

It is the sincere purpose of this Service to provide every possible benefit that the monthly dues will permit. In the interest of the membership as a whole it is necessary that reasonable safeguards should be set up in order to avoid undue and unwarranted losses. For this reason, coverage does not apply to cases provided for under Workmen's Compensation; injuries resulting from brawls, riots or insurrection; insanity, alcoholism or drug addiction; acute venereal diseases; obstetrics; willful self-inflicted injuries; pulmonary tuberculosis; and virulent contagions such as smallpox, scarlet fever, etc.

In the event treatment is rendered for accidental injuries and the expense of such treatment is included as part of damages recovered for such injuries, then a member shall reimburse Hospital Service, Inc., to the extent that such expense is recovered.

The cost of this service is but a few cents a day. Well within the reach of everyone. Rates are based upon the number of persons in the family, and whether ward or private room service is desired. There is a small registration fee payable at the time of becoming a member.

Special rates will be allowed for employed groups where 75 per cent of the employes desire to subscribe.

MUST AMEND LAW

Establishment of group hospitalization in New York City, recently proposed by several hospital organizations, can only be affected by a change in the existing law according to a ruling by State Superintendent of Insurance George Van Schaick, the United Hospital Fund, New York, has learned. Advocates of the plan will give further study to the question with a view to introducing a bill at the next regular session of the Legislature. Under the plan proposed, employes desiring to avail themselves of such service would authorize employers to deduct 90 cents a month, or $10.80 a year, from their pay. They would become eligible under certain conditions for three weeks of semi-private hospital care a year and would be treated by their own physician.

Superintendent Van Schaick holds that this plan constitutes insurance and that the present law is not broad enough to empower him to authorize its establishment.

WHO'S WHO IN HOSPITALS

ONE of the reasons for the success achieved so consistently by the Ohio Hospital Association has been not only the selection of trustees and general cooperation of the people of the state, but also the selection of the man for the post of executive secretary. The Buckeye State Association seems to be uniformly happy in the choice of its executive secretary, as is testified by appointment of A. E. Hardgrove, superintendent of the City Hospital of Akron, to succeed J. R. Mannix, University Hospitals, Cleveland, who maintained the traditions of this office in the oldest state association so well. Mr. Hardgrove has been in charge of the City Hospital of Akron since September 1, 1922, during which time the institution has made a material growth in capacity as well as undergone a considerable modernization and expansion of services. Mr. Hardgrove majored in chemistry at Buchtel College, now the University of Akron, and after a year of graduate work at Ohio State University he returned to his home town to organize the office of city chemist. When Buchtel College became the University of Akron the city chemist was transferred to the university under the title of director of bureau of city tests and assistant professor of chemistry. Besides his active interest in the Ohio Hospital Association, Mr. Hardgrove has extensive contact with civic and club programs.

Sister Mary Attracta has succeeded Sister Lidwina as director of the school of nursing of Mercy Hospital, Chicago.

F. Stanley Howe, director of Orange Memorial Hospital, Orange, N. J., and Cora Gould, purchasing agent of that hospital, cooperated in the planning and purchasing of equipment of the new Morris Schinasi International Hospital in Manissa, Turkey.

Sister Mary Joseph, formerly superintendent of St. Vincent's Hospital, Indianapolis, and still connected with the institution, recently celebrated her golden jubilee as a member of the Daughters of Charity of St. Vincent de Paul.

Dr. John A. Pringle is the new manager of the Veterans' Administration, North Chicago, succeeding the late Dr. H. R. Carson. Dr. Pringle came to North Chicago from Little Rock, Ark., at which point he has been succeeded by Dr. John H. Baird.

Sister Mary Xavier, superintendent, Mercy Hospital, Cadillac, Mich., has been transferred to Bay City, Mich., and will be succeeded at Cadillac by Sister Mary Liguori of Mercy Hospital, Jackson, Mich.

Grace G. Grey has been appointed assistant principal of the Miami Valley Hospital School of Nursing, Dayton, O. Miss Timoxena Sloan is the new educational director.

Pauline Hyman has been named chief dietitian at the Miriam Hospital, Providence, R. I.

A. E. HARDGROVE

Superintendent, City Hospital, Akron, O., Secretary, Ohio Hospital Association

Walter W. N. Righter is superintendent of Presbyterian Hospital, Philadelphia, having recently been elected to that post after acting superintendent since the resignation of Charles S. Pitcher in June. Mr. Righter formerly was assistant superintendent.

Mabel Wheeler recently became superintendent of Gifford Memorial Hospital, Randolph, Vt. She previously was superintendent of Somerville Hospital, Somerville, Mass., for several years. The Gifford Memorial Hospital until recently was known as Randolph Sanatorium, and the name was changed to honor the founder of the institution who died a short time ago.

Ursula D. Payne, superintendent of the Moline, Ill., City Hospital for nearly thirteen years, has resigned, effective December 1.

Miss Payne's tenure of office was marked with important expansions and numerous improvements of the plant and service of the institution, including the construction of a $150,000 addition, installation of laboratory and X-ray departments and the retirement of a $100,000 debt. The school of nursing improved in character and increased in size during her regime.

Miss L. C. Anderson has resigned as superintendent of the Sycamore, Ill., Hospital. Mary Boynton will act as business manager.

Dorothy M. Gleason recently assumed her duties as dietitian at St. Mary's Hospital, Evansville, Ind.

Frank A. Crothers, assistant superintendent of the Springfield, O., City Hospital, has been appointed acting superintendent, succeeding Charles E. Findlay, who resigned to become superintendent of Butterworth Hospital, Grand Rapids, Mich.

Myrtle McAhren, superintendent of nurses of St. Luke's Hospital, Cedar Rapids, Ia., recently was named president of the Iowa State Nurses' association.

Maxwell Lewis recently was given complete administration of Sydenham Hospital, New York City.

Dr. N. W. Faxon, superintendent, Strong Memorial Hospital, Rochester, N. Y., and president of the American Hospital Association, completed his committee appointments by November 1, thus giving no committee chairman or member an excuse for incomplete or hurried work because of lack of time.

Dr. M. T. MacEachern, American College of Surgeons director of hospital activities, again is chairman of the publicity committee of the A. H. A., but the name of the committee has been changed from "committee on public relations" to "committee on public education." The change was made because of confusion with the council on community relations which was apparent from time to time.

Rev. Harry E. Hess, superintendent, Nebraska Methodist Hospital, Omaha, attended a recent meeting of the Chicago Hospital Association while in that city.

Dr. John H. Snoke, formerly in charge of Bryn Mawr, Pa., Hospital, and a well known figure in Pennsylvania hospital circles, now is superintendent of the University of Georgia Hospital, Augusta.

Reducing Food Waste Best Way to Lower Cost of Food

By LENNA F. COOPER
Administrative Dietitian, Montefiore Hospital, New York, N. Y.

AN analysis of the methods proposed for reducing food costs reveals the following:

1. Lowering of quality of food served.
2. Lowering of quantity of food served.
3. Prevention of waste.

The lowering of the quality may be affected by the substitution of less expensive and therefore less attractive foods for the more expensive items or by the elimination of certain so-called non-essentials. Before a lowering of quality is affected, several questions should be answered:

1. Will this policy lower the dietary standards?
2. Will the attractiveness of foods served be so affected as to increase food waste?
3. Will your clientele be satisfied?

Certainly no institution caring for sick or well is justified in feeding those under its care a ration inadequate to maintain a normal physical status, and in the case of the sick a diet suitable for promoting recovery as quickly as possible. One should, therefore, carefully examine the per capita consumption of milk, eggs, fresh fruits and vegetables, the factors of safety in the diet, to see that they are adequate in amounts. Surveys should also be made to see that the total food value is sufficient.

A lowering of the quality of the food supply is very apt to increase food waste. It must be remembered that the less expensive the menu, the more skill is required to give satisfaction and the more dressing up it will need. For example, a teaspoon of relish or jelly beside an inexpensive serving of meat will often make the less expensive cut acceptable. Foods lacking in flavor, such as a poor quality of canned foods, usually cost within a few cents per can of a good grade and more than likely will be eaten not at all or only in part.

The food habits and tastes of both patients and personnel must be considered. A patient who is accustomed to fresh peas the year round will hardly accept canned ones of any grade. The "satisfied guest" is the goal even in these difficult times.

It would seem, therefore, that before the quality and quantity consumed is lowered, one should investigate the third method of reducing food costs—the lowering of food waste. Any food which lands in the garbage can is an expensive item.

"Waste is a specter that stalks everywhere. It may be found in overpurchases or unwise purchases, in the refrigerator, in the preparation and in the distribution of food. In a hospital, the greatest source of waste is usually in the wards. This varies in quantity for the following reasons: (1) the quality of the food served; (2) poor cooking; (3) careless handling of food; (4) too frequent serving of the same dish; (5) the size of servings; (6) the severity of the illness of the patients; (7) the type of medication and treatment; (8) the amount and nature of food contributions from the outside."—How to Maintain a Smooth Running Dietary Department. By Lenna F. Cooper. Reprinted from The Modern Hospital, Vol. XXXIX, No. 4, October, 1932.

There are three methods in use for investigating food waste: (1) inspection, (2) measuring, (3) weighing. Inspection of food waste is important because it gives an idea as to the popularity of dishes, the quality of food served, and the suitability of size of servings. When confronted by a relatively large food waste on a single ward, one may suspect larger servings than necessary. When a relatively large food waste occurs on all wards, one must suspect unpopularity of the food either because of the food itself or because of the way in which it is prepared. Variety must be had, even though one food is not as popular as another. But an effort should be made to prepare the unpopular food so appetizingly that with smaller servings it will "go over." Especially is it necessary to have variety when serving the same people over long periods of time.

Food inspection is valuable when made by the persons responsible for (1) the serving of food, (2) the planning of menus, (3) preparation of the food. Since it is merely a measuring by the eye, it is chiefly valuable to the one making the survey as the impressions made thereby are difficult to convey to others with any degree of accuracy. As a control, it is valuable chiefly to small institutions. When relied upon as the only measure in large institutions, it requires a great deal of supervision, which, of course, is expensive. Even so, it still remains an inaccurate method.

The measuring of food waste is reported by a few hospitals. This method, it would seem, still lacks the accuracy to be obtained by weighing.

The results obtained by the weighing of food waste are tangible and impartial. They speak for themselves. Through them it is possible to fix responsibility; through them it is also possible to establish healthy competition among the groups concerned. The chief value of this procedure is the publicity given the results and the knowledge that the administration is cognizant of the good and the bad. This may be accomplished by a simple form.

The weekly food waste report is shown on page 52.

This is posted on the bulletin board on each ward, the kitchens, the dietitian's office, and the nursing office. Copy is also kept in the directors' office. It is the duty of a dietitian to post the weekly averages in each of the above places. A card announcing the number of ounces of food waste per capita for the week previous for each dining-room is placed on the respective bulletin boards.

Employes and patients should be informed of the efforts to prevent undue waste. Employes must be instructed to serve what might be termed small servings, but it must also be made clear to both patient and employe that second helpings may be

From a paper before 1933 A. H. A. convention.

Rouse Sluggish Appetites

This new china transforms any diet into a tempting feast

Even a simple inexpensive pattern becomes a work of art on Adobe Ware.

Extravagant as it may sound, Adobe Ware does seem to have the almost magical effect of changing completely the appearance of even the simplest diet. It brings out, in full brilliance, the colors which nature herself has given foods. It blends these colors against a mellowing enticing background that pleases the eye—stimulates the appetite. Even the most reluctant patient eats with zest. The optic nerve stimulates the gastric juices—and you know the rest.

Many dietitians and physicians have said some pretty nice things about Adobe Ware. They point to several advantages resulting from its use. It builds up the patient's appetite and general morale. It will cause no end of favorable comment from patients when they leave. It has a very practical advantage of lowering replacement cost.

Adobe Ware is like all Syracuse China. It is vitrified—will not chip, mar or fade. The most accurate cost records of present hospital users reveal a cost difference between this china and plain clumsy ware, so small it can hardly be measured. We would like to send you some experience stories from these hospitals—cold figures that speak volumes.

Forget your budget worries, if only for a day. Spend that day looking over this new Adobe Ware. Sample stocks are with leading dealers in all principal cities. Names and addresses will be supplied upon request. Price some patterns—you don't have to buy. But you should know about this new china.

Onondaga Pottery Company, Syracuse, New York. *New York Offices:* 551 Fifth Avenue. *Chicago Offices:* 58 East Washington St.

adobe ware SYRACUSE CHINA

New Adobe Puree Bowl

Expresses in shape as well as color Adobe's rich historical background.

SYRACUSE CHINA

A PRODUCT OF ONONDAGA POTTERIES

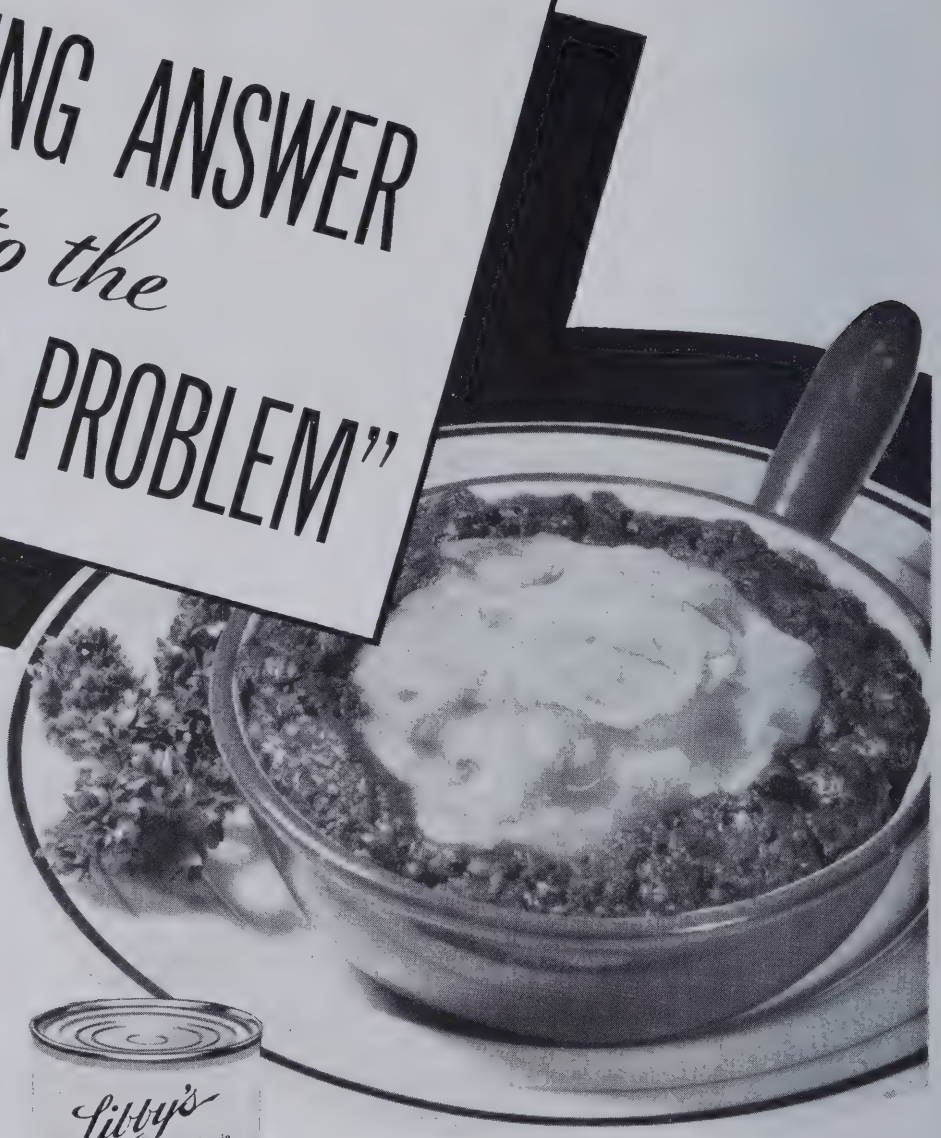
"Potters to the American People Since 1870"

New Shapes for Tea

An artistic and very practical new departure in tea and hot water pots, a most appealing group.

Syracuse China is *American* china made by *American* workers

Try this INVITING ANSWER to the "SPINACH PROBLEM"



No doubt about it, most dietitians do have a "spinach problem" . . . and not only in the Children's Ward either. So many special diets call for spinach, and so many patients are, to say the least, not enthusiastic.

Next time you're up against this difficulty, try the dish shown here. We think you'll find it a popular solution. It is tempting because of its novelty; satisfying because it is made with *Libby's* Spinach.

For Libby's Spinach has points that make it very definitely more attractive than ordinary kinds. Tender young leaves, washed absolutely free from sand and grit, are cooked under pressure within a few hours of picking. That way, both the delicate natural flavor and the important vitamins and minerals are protected.

You will find Libby's Spinach economical. It costs you no more, and full uniform pack, without waste, is assured. Patients and staff will enjoy its pleasing flavor and unusual delicacy.

Next time you order, make it *Libby's* Spinach. You can get it and other fine Libby Foods through your regular source of supply. Libby, McNeill & Libby, Dept. HM-35, Welfare Bldg., Chicago.

NRA

SPINACH AND CHICKEN, *shown above, is a suggestion for Diabetic and Anti-Constipation trays as well as for the general diet.*

Recipe: Drain Libby's Spinach and chop fine. Season well with butter and a dash of nutmeg. Place in individual baking dish; make hole in center of spinach and fill with cubes of boiled chicken in cream sauce (for Diabetic trays, pure cream thickened with India gum). Heat in oven, and serve very hot.

Libby's 100 Foods

These Libby Foods of finest flavor are now packed in regular and special sizes for institutions:

Tomato Juice
Tomato Purée
Catchup, Chili Sauce
Hawaiian Pineapple
California Fruits
Red Raspberries
Santa Clara Prunes in Syrup
Strawberries
Loganberries
California Asparagus
Stringless Beans
Peas, Corn, Beets
Spinach, Kraut
Pork and Beans
Jams, Jellies
Olives, Pickles
Mustard
Bouillon Cubes
Beef Extract
Mince Meat
Boneless Chicken
Salmon
Evaporated Milk

had for the asking. One hospital with an exceedingly low food waste found that its patients were losing weight and therefore would caution against too much emphasis on the subject. It is almost imperative that some provision be made for passing food through the ward for additional helpings. Patients will usually cooperate when requested to inform attendants when they do not wish any one item on the tray. They become interested in keeping their ward waste low. Ward or contact dietitians can do much toward the education of the patient and in ascertaining likes and dislikes.

Standardized portions are helpful when adapted to the needs of each unit, the women's wards receiving smaller servings than the men's, for example. Surgical patients who are able to receive a tray require more food than cancer or cardiac cases. The portion should be standardized to meet the need of the type of patient on any given ward.

When possible to do so, a selective menu is advisable as a means of preventing food waste. When no choice is offered, it is wise to have in each ward pantry a few simple foods which may offer a substitute for those who are so unfortunate as to dislike any substantial part of the meal. These may include ready-cooked cereals, milk, cheese, or hard-boiled eggs, the yolks of which are easily digested and palatable. Patients appreciate this slight attention.

The type of food service has a marked effect upon the food waste. The tray that is delivered fully set up with everything from soup to dessert thereon offers little opportunity for the patient to refuse certain undesired dishes. Some of the food will be too cold to be palatable before the patient is ready to partake of it. The serving of the food in course not only gives satisfaction, since hot food is always hot, but when properly managed, tends to prevent waste. This may be accomplished by serving from the food-truck in the ward or it may be done from a ward pantry. In the latter case the tray is set up with napkins, silver, dishes and such cold foods as bread, butter and salad, also the dessert if it is cold. Soup is passed in individual bowls, then the meat plates with potatoes and possibly the vegetable. When unsuitable to serve in the plate, the vegetable is served in an individual vegetable dish, in which case it is best to serve it before the meat, so the patient may have it to eat with that course. Tea, coffee and milk may be poured at the bedside.

The weighing of garbage is an economical process. One man can do all

MONTEFIORE HOSPITAL

DAILY FOOD WASTE

Breakfast_____
Dinner_____
Supper_____ √

WARDS

Date August 6, 1933

WARDS	CENSUS	EDIBLE	CHIEF CONSTITUENTS	INEDIBLE	CHIEF CONSTITUENTS	EDIBLE PER CAPITA
C-I	59	8#	Meat, potatoes		Orange rinds	
C-II	61	4	Noodles, asparagus		Paper, egg shells	
C-III	61	4				
C-IV	61	3½				
S-I & II	75	5	Meat			
S-III & IV	88	12			Potato skins	
E-I	32	4	Bread			
E-II & III	34	4½				
W-I	31	3½	Spinach		Bones	
W-II	28	3				
Private A	11	1	Lettuce		Orange skins	
" C	20	3	Cake			
Schiff Pav.	111	10				
DINING ROOMS						
Staff	81	7	Meat, vegetables		Coffee grounds and tea balls	
Nurses	170	12	Bread			
Employees	178	10	Asparagus		Bones	
KITCHENS						
Main	965	52			Bones, skins, etc.	
Diet	140	3				

Form for recording daily food waste.

of the weighing and recording for a hospital of 2,000 beds or more. At Montefiore, a 700-bed hospital, one man does the work in three hours each day. Some hospitals weight two weeks out of each month, others one week, while still other weight one or more days each week. Better results are obtained, it is believed, if the weighing is done daily, as patients and personnel soon learn to take "special precaution" on weighing days. The equipment needed is simple. A room, preferably near the incinerator, or the garbage storeroom, equipped with a platform scale and two containers for each unit, is all that is necessary. The containers may consist of two cans, or one can and a pail. One ingenius dietitian uses a No. 10 can for the second container. By using uniform containers it is an easy matter to make deductions for their weight.

The two containers are for edible (avoidable) and inedible. Some hospitals do not attempt to separate their plate waste, but since the object of the weighing is to prevent unnecessary waste, it seems wise to differentiate between the avoidable and unavoidable. If the garbage can is filled chiefly with watermelon rinds or bones, for example, there is no argument for economy when the waste runs high. Liquids should not be included as edible waste, especially tea, coffee, and clear soups. Some hospitals do include milk and the thicker soups. When it is remembered that one glass of milk weighs almost as much as the meat, potato and vegetable, yet costs only a fraction as much, it is doubtful if its inclusion is warranted since it may make comparisons difficult.

The form for recording daily food waste is shown above.

For guidance in classifying waste, the following note appears on this form:

Edible waste is any food which could have been eaten.

Inedible waste is that portion of food served which could not have been eaten such as melon rinds, orange skins, potato skins, egg shells, bones, tea balls, prune, plum and peach pits, apple peelings.

Do not include liquids such as tea, coffee, milk or soup. If soup contains solids, use strainer or colander to separate from the liquid.

Unfortuntaely, there is no established "standard practice" in regard to food waste accounting, and no standards for the quantity of waste. Fortunately, each institution is able to set its own standard from its own experience and to establish its rules and regulations which, if uniform throughout the house, form an equitable basis for comparison.

In the hope of securing sufficient data to form a basis for comparison

EDIBLE FOOD WASTE

(Expressed in ounces per capita per day)

Institution	1930				1931				1932				1933 Jan. 1-June 30			
	Patients	Doctors	Nurses	Employees	Patients	Doctors	Nurses	Employees	Patients	Doctors	Nurses	Employees	Patients	Doctors	Nurses	Employees
State Hospital No. 1 (Mich.)	...	...	...	...	...	...	...	...	...	...	...	...	1.0	...	0.6	...
State Hospital No. 2 (Mich.)	...	...	...	...	...	...	...	...	2.0	...	...	...	1.5	...	...	1.8
State Hospital No. 3 (Mich.)	1.9	6.5	2.2	3.3	1.5	3.3	3.8	1.8	1.3	2.4	3.2	2.6	1.2	1.9	1.6	1.3
State Hospital No. 4 (Mich.)	...	...	...	...	...	...	...	...	...	...	...	...	1.6	3.6		1.1
T. B. Sanatorium (Mich.)	...	...	...	...	...	...	...	...	13.4	6.7	...	3.5	13.3	5.0	...	3.0
23 Hosp. of U. S. Vet. Adm.**	...	...	...	...	...	...	...	...	7.2	...	...	...	7.2	...	...	...
7 State Hosp. of Pa. (mental)	...	...	...	...	...	...	...	...	...	...	...	...	.5-8.0	...	...	...
5 State Hosp. of Pa. (med and surg.)	...	...	...	...	...	...	...	...	...	...	...	...	.3-1.3	...	...	...
4 State Inst. of Pa. (feeble minded and epileptics)	...	...	...	...	...	...	...	...	...	...	...	...	.5-1.9	...	...	...
3 State Penitentiaries of Pa.	...	...	...	...	...	...	...	...	...	...	...	...	1.1-3.5	...	...	...
Harbor View Hosp., Seattle	...	...	...	...	5.0		7.0		4.5		7.0		3.5		6.0	
Montefiore Hosp., New York	12.6	11.5	5.5	8.8	10.1	5.0	3.9	6.3	9.0	6.0	6.5	7.5	6.0	7.5	5.5	5.5
Barnes Hospital, St. Louis	...	...	...	...	...	...	...	...	18.0*	...	...	...	17.0*	...	...	...

*The figures include all waste—edible and inedible.

**These figures are for the month of January only of the two years indicated.

between institutions of similar type, your speaker has attempted to collect the information that is available. The literature on the subject is scarce. Rosenau* in the 1917 edition states that the food refuse in the Borough of Manhattan averages 200 pounds per person per year, or 8.8 ounces per day. Early in the world war, record was kept for one year of the food waste in three large army camps. The averages were as follows: (1) 0.91 pound, (2) 0.956 pound, (3) 0.85, or 14.5 ounces, 15.3 ounces, and 13.6 ounces, respectively. Later, the Surgeon General's office made a nutritional survey† of 427 camp messes, which were operating more normally than at the beginning. The average total waste was 0.8 pound per person per day. Of this amount, the edible portion was 0.38 pound or 6 ounces per person, and its cost was found to be 3.2 cents per capita or 7.9 cents per pound. Toward the latter part of the war, many of the camps and base hospitals effected great savings, Camp Custer base hospital making an especially good record. Dr. Irons, the commanding officer, writes‡ as follows, regarding their effort to reduce waste:

"By urging the necessity of conserving foods, and by a general supervision of messes, the average waste per ration (per person per day) derived from edible food, was reduced to between 1.50 ounces and 2 ounces. Thus the daily hospital average for all messes for the week ending July 28, 1918, was 1.85 ounces. At this point the inspection and weighing of table waste from each ward and each mess was instituted, and the edible waste fell progressively. For the week ending August 4, the average was 1.25 ounces; August 11, 1.22 ounces; September 7, 0.30 ounce; September 28, 0.15 ounce. For the months of September and October, including the first portion of the influenza epidemic, with its attendant strain on the personnel, the average waste for 134,730 rations was 0.26 ounce.

"The saving thus made possible by detailed inspection may be expressed more clearly if reduced to money values. The difference between the average of 0.26 ounce and the average waste of 1.85 ounces, which itself was a low figure compared to that found by the food division, was approximately 1.5 ounces. When this apparently insignificant saving is multiplied by the number of rations served, it is found that 12,000 pounds of edible food were saved in two months at a time when the conservation of food, independent of its money value, was of vital importance. Careful studies of costs of food made at this time showed that at the quartermaster prices the cost of food as served was approximately 10 cents per pound. The money value of the savings was therefore $1,200."

While our present wholesale food prices, based on figures from the U. S. Bureau of Labor statistics, are just about one-half those of 1917, our hospital dietaries are usually more expensive than that of the army ration. From three surveys of one week each conducted by the nutrition department of Montefiore Hospital, it was found that approximately four pounds of cooked food, exclusive of tea and coffee, was served daily to patients on the general wards. The cost was approximately 36 cents. It would seem, therefore, that our hospital food waste may still be valued at from 8 to 10 cents per pound.

How glad we are when our per capital food cost drops one or two cents. Can you think of any better way of saving that amount or of having it with which to buy better and tastier food than by the simple act of keeping it out of the garbage can?

The following questionnaire was sent to a few hospitals and organizations known to have weighed their garbage:

1. Do you have your garbage weighed?
2. Do you have it separated into edible and inedible (separating such things as melon rinds, orange skins, bones)?
3. Do you withhold liquids, including milk and soup, from your edible garbage?
4. If you have your results, would you kindly give your average figures by the month for 1933 to date and, if possible, the yearly or monthly average of 1932 for the following groups?
   Patients (ward waste).
   Staff, doctors, nurses.
   Employes.
   (If you have any data earlier than 1932 which will show the advantage of weighing, please send also.)
5. Have you seen any definite results from the weighing of garbage? If so, what?
6. What methods have you used to stimulate interest among those concerned in the plan?
7. Will you furnish a copy of any instructions which you give your employes who handle the food waste?

The accompanying table shows the results of the above questionnaire.

Almost all report favorable results and show definite savings by the practice of weighing food waste as indicated by the following statements:

"Less food is cooked. Both patients and employes are more careful not to ask for more than they can eat and are just as happy as when wasteful"; "Food department employes more interested in uniform serving of food"; "There has been a reduction in the amounts of food used yearly since 1930"; "A definite reduction"; "Food waste for July, 1933, just one-half that of July, 1932"; "Nurses more careful, and attendants also, as to the amounts served"; "The large institutions (of Pennsylvania) found waste accounting of value as a check on food consumption, the menus, food preparation, and amounts ordered and prepared."

By reference to the accompanying tables it will be noted that in each of the 49 institutions' reports there was a decrease as a result of the weighing. Many of them begun the practice only this year, although several of the Pennsylvania institutions have been doing so for a number of years, and it will be seen that their averages are

*Preventive Medicine and Hygiene, by Milton J. Rosenau. Published by D. Appleton & Co.

†American Journal of Public Health, 1919. Vol. IX. No. 6, Page 401.

‡Modern Hospital. Vol. XIV, February, 1920, Pages 144-145.

● *Monel Metal cold and hot table, cereal cooker and ventilator in Monroe County Home and Hospital in Rochester, N. Y. Installation by Holderle Bros. of Rochester, N. Y. Architect: Sigmund Firestone, Rochester, N. Y.*

See how Monel Metal is used from floor to ceiling in the Monroe County Home and Hospital's Kitchens

● Here was a rare opportunity... and Holderle Bros. made the most of it. It was an opportunity to demonstrate what the kitchens in a public building can be, and should be.

By designing an efficient layout and by taking full advantage of the virtues of Monel Metal wherever possible, Holderle Bros. provided kitchens that defy the ravages of wear and time... kitchens that reflect the foresight of the men and women who created this hugh Rochester institution... kitchens that will never depreciate nor run up large maintenance bills.

Not only are the sinks and table tops made of Monel Metal, but even the legs and fittings, the ventilators and the stove pipes, too! And, in addition to the equipment shown here, there are 36 long dining tables (seating a total of 540 persons) all with tops made of the same rust-proof Nickel alloy.

Good for a long Parade of Years

Such food service equipment will continue for years and years to be a model of cheerfulness and low cost operation.

Cheerful, because of Monel Metal's bright, silver-like surfaces.

And low in operating costs because Monel Metal is absolutely rust-proof, highly resistant to corrosion and easily and quickly cleaned. Its steel-like strength practically eliminates need of repairs or replacement.

Furthermore, Monel Metal equipment is solid metal right through, so there is no coating to chip, crack or wear off. Year in year out this equipment *takes it on the chin*... hard knocks, rough treatment...yet it goes on shining as brightly as ever.

Let us tell you of the many other important hospitals using Monel Metal equipment, not only in their food service departments, but in clinical departments and laundries as well. Just drop us a card.

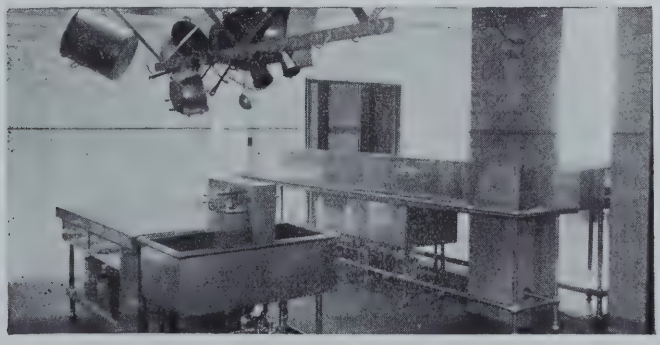
THE INTERNATIONAL NICKEL COMPANY, INC., 67 Wall St., New York, N.Y.

Monel Metal is a registered trade-mark applied to an alloy containing approximately two-thirds Nickel and one-third copper. Monel Metal is mined, smelted, refined, rolled and marketed solely by International Nickel.

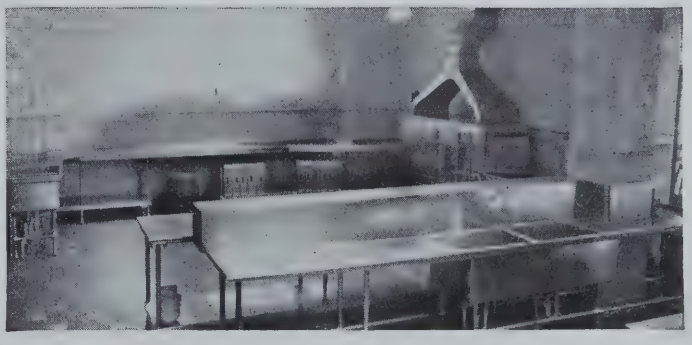
NRA WE DO OUR PART

MONEL METAL

INCO MONEL METAL



● *Monel Metal chef's table, vegetable sink and sinks installed by Holderle Bros. in the Monroe County Home and Hospital.*



● *Monel Metal dish tables and sinks fabricated by Holderle Bros. and installed in the Monroe County Home and Hospital.*

MONTEFIORE HOSPITAL

WEEKLY FOOD WASTE REPORT

Daily average per capita
for preceeding period 6 Oz. Patients
Jan. - July 1933

	CENTRAL				SOUTH		EAST		WEST		PRIVATE		Schiff	Pa.				
Date	1	2	3	4	1	3	1	2	1	2	A	C	Pav.	Ave.	Drs.	Nur.	Emp.	D. R. Av.
Aug.																		
6-12	5.5	4.5	5.0	2.5	8.0	8.0	3.0	3.5	4.5	2.0	8.5	4.0	6.5	5.0	4.0	3.0	3.5	3.5
13-19	7.0	4.5	3.0	3.0	5.0	6.5	4.0	3.5	5.0	3.5	9.0	4.0	5.0	5.0	3.5	2.5	3.5	3.0
20-26	7.5	5.5	3.0	3.5	5.0	5.5	5.0	3.5	5.0	4.0	10.0	4.5	4.0	5.0	4.5	3.5	3.5	4.0
27-2	6.5	4.5	4.0	3.5	6.0	5.0	4.5	4.5	5.0	4.0	7.5	6.5	3.5	5.0	4.5	3.5	3.0	3.5
Aver.	6.5	4.5	3.4	3.0	6.0	6.0	4.0	3.5	5.0	3.5	8.5	4.5	4.5	5.0	4.0	3.0	3.5	3.5

Weekly food waste report.

low. A few of the Michigan hospitals have also been weighing for some time and their averages are low. In the Pennsylvania institutions the range of the averages is given. The range of patient's food waste for the entire group except Barnes Hospital is from .3 to 13.3 ounces per capita per day for the year 1933. Eighteen of the hospitals show daily averages under 3 ounces, three have averages between 3 ounces and 6 ounces, 27 average 6 ounces or above. (We assume that the 23 hospitals of the Veterans' Administration, whose average is 7.2 ounces, are all above this number.) Barnes Hospital does not separate its waste in any way; its figures, therefore, include all plate, kitchen and preparation waste. Harbor View Hospital reports a preparation waste of 5 ounces per capita per day for 1931, 4.5 ounces for 1932, and 4 ounces for 1933, respectively.

The writer will not attempt to draw conclusions from the above study, realizing that the number of institutions reporting are far too few and of too varied a type to make accurate deductions. As has already been stated, there are a number of factors which will undoubtedly affect food waste, such as (1) the type of patient. From figures included in the reports from hospitals (but not shown in the summary) it would seem that wards and institutions for the tuberculosis patients have a higher waste than the average ward and hospital wards where special diets predominate are also high, due no doubt to the fully set up tray. Private patients expect and demand a greater choice of food with a resultant higher food waste. A hospital with a large number of private patients may expect a proportionately higher waste. (2) The type of food service affects the quantity of waste. Many of the hospitals report a higher food waste for the units having cafeteria service. This is especially true when a selective menu is offered *unless* it is a pay cafeteria, a charge being made for each dish. The fully set up tray for patients is also conducive to waste for reasons stated above. (3) The interest of employes who prepare and serve the food is a large factor, and this in turn depends upon the interest shown by those higher up. The dietitians can do much to keep up this interest, but the backing of the administration is the greatest factor in creating and maintaining a high morale in this regard. (4) The interest and cooperation of the patient is also developed by instruction and by close supervision, making him realize that someone is cognizant of his wastefulness. Tact, of course, must be used in imparting this information.

In attempting to analyze the figures submitted by the institutions listed in the above table, it became apparent that there is great need for standards and of standard practice in regard to determining per capita food waste. It is hoped that some organization such as the American Hospital Association will undertake such a task. Standards are needed as to:

1. Quantity (pounds, ounces or grams) per patient per day (or meal) for both edible and inedible waste.
2. Quantity (pounds, ounces or grams) per staff member per day (or meal) for both edible and inedible waste.
3. Quantity (pounds, ounces or grams) per nurse per day (or meal) for both edible and inedible waste.
4. Quantity (pounds, ounces or grams) per employe per day (or meal) for both edible and inedible waste.
5. Classification of foods as to edible and inedible.
6. Separation of liquids.

Of the methods studied, it would seem that those of the U. S. Veterans Bureau* offer the best in standard practice. "In the hospitals of this Service, the quantities of food prepared and the size of servings are estimated closely. After each meal, left-over food is returned from ward kitchens and serving rooms to the main kitchen, where the Chief Dietitian issues instructions regarding the proper disposition of it. All food waste is separated into edible and inedible garbage, placed in cans labeled accordingly, and sent to a central refrigerated section where it undergoes careful inspection by dietitians and others concerned. Edible waste includes all food that would be eaten normally, such as pieces of bread, meat or vegetables left on plates, while inedible includes such items as egg shells, coffee grounds, potato skins or orange peel. Every effort is made to prevent the addition of liquids to this kind of waste by the use of sink strainers and colanders. Careful daily records of the weights of the edible and inedible garbage are kept at each station, and figures showing monthly totals, as well as average daily amounts per person, are included in the Chief Dietitian's monthly reports to the Central Office. Garbage from the diet kitchens and wards is sent down after each meal by a ward attendant. This garbage is examined by dietitians or the officer of the day, and notations or rejections made and the garbage carefully weighed and weights recorded. The records of separate weighing from dining halls and diet kitchens is posted weekly in these places for information."

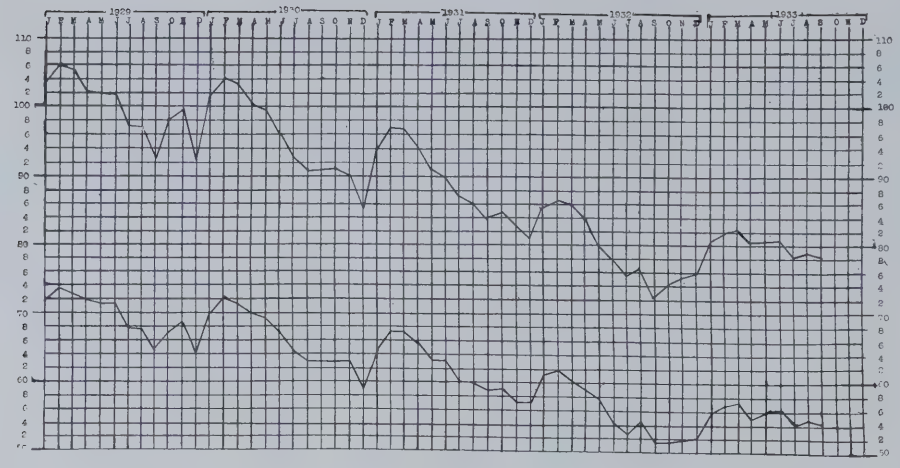
From my own experience in the weighing of food waste, I am convinced that it is very worth-while. Our food quantities go up and down with our food waste.

Our program of weighing was interrupted during the last half of 1931 and the first half of 1932 because of the modernization of our entire department, necessitating our beginning over again so far as our educational program was concerned. Nevertheless, our patients' waste is now less than half what it was when we began, our August figure being 5 ounces. A "drive" was instituted against waste in our personnel dining-rooms and cafeteria, resulting in a 5 ounce average. While our goal is not yet reached, I am confident that the expense involved has been a splendid investment.

While this procedure may not be practicable for all hospitals, and the results in one hospital may not be the standard desired by another, there is no doubt that the weighing of garbage is an economical and effective method of control when given the proper publicity and the support of the officials of the institution. Like all other educational programs, it can not be accomplished in a day, or a month, or a year—but persistent and consistent effort will have its reward.

The writer is greatly indebted to the various directors, stewards and dietitians for information given in answer to our questionnaire.

*Unpublished data obtained through correspondence.



This graph shows the percentage of occupancy in 91 general hospitals in 87 communities in 35 states, with a basic bed capacity of 16,922. The upper line is based on the use of average 1929 occupancy as 100 per cent, and the lower line was drawn to show actual percentage of occupancy to normal bed capacity.

Total Daily Average Patient Census

January, 1929	11,919
February, 1929	12,335
March, 1929	12,253
April, 1929	12,114
May, 1929	11,981
June, 1929	12,025
July, 1929	11,473
August, 1929	11,548
September, 1929	11,157
October, 1929	11,590
November, 1929	11,736
December, 1929	10,977
January, 1930	12,048
February, 1930	12,425
March, 1930	12,408
April, 1930	12,128
May, 1930	12,044
June, 1930	11,601
July, 1930	11,290
August, 1930	10,997
September, 1930	11,015
October, 1930	11,086
November, 1930	11,005
December, 1930	10,524
January, 1931	11,510
February, 1931	11,991
March, 1931	11,970
April, 1931	11,669
May, 1931	11,251
June, 1931	11,187
July, 1931	10,765
August, 1931	10,657
September, 1931	10,409
October, 1931	10,499
November, 1931	10,266
December, 1931	10,145
January, 1932	10,758
February, 1932	11,038
March, 1932	10,888
April, 1932	10,596
May, 1932	10,082
June, 1932	9,927
July, 1932	9,571
August, 1932	9,748
*September, 1932	9,125
*October, 1932	9,226
*November, 1932	9,328
December, 1932	9,403
January, 1933	10,037
February, 1933	10,197
March, 1933	10,222
April, 1933	9,957
May, 1933	10,004
June, 1933	10,023
July, 1933	9,786
August, 1933	9,809
September, 1933	9,716

Receipts from Patients

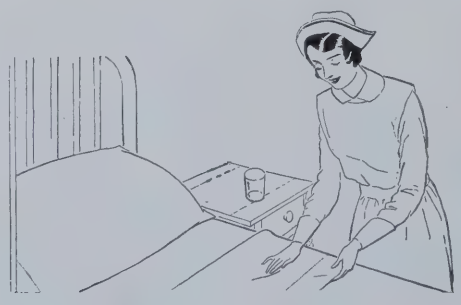
January, 1929	1,795,843.79
February, 1929	1,776,040.82
March, 1929	2,024,823.11
April, 1929	1,929,175.70
May, 1929	1,920,982.43
June, 1929	1,874,173.11
July, 1929	1,846,899.32
August, 1929	1,867,706.24
September, 1929	1,772,230.39
October, 1929	1,828,051.39
November, 1929	1,786,036.71
December, 1929	1,737,404.65
January, 1930	1,840,418.05
February, 1930	1,799,080.00
March, 1930	2,003,309.58
April, 1930	1,927,493.30

"How's Business?"

May, 1930	1,921,523.05
June, 1930	1,817,813.00
July, 1930	1,803,315.00
August, 1930	1,719,634.00
September, 1930	1,700,314.00
October, 1930	1,741,017.00
November, 1930	1,640,374.00
December, 1930	1,687,813.00
January, 1931	1,771,812.00
February, 1931	1,720,474.00
March, 1931	1,881,003.00
April, 1931	1,831,228.00
May, 1931	1,815,096.00
June, 1931	1,743,189.00
July, 1931	1,698,277.00
August, 1931	1,598,869.00
September, 1931	1,555,436.00
October, 1931	1,583,005.00
November, 1931	1,497,948.00
December, 1931	1,521,552.00
January, 1932	1,527,159.00
February, 1932	1,468,059.00
March, 1932	1,574,446.00
April, 1932	1,496,077.00
May, 1932	1,453,746.00
June, 1932	1,417,856.00
July, 1932	1,357,096.00
August, 1932	1,327,016.00
September, 1932	1,244,635.00
*October, 1932	1,248,504.00
*November, 1932	1,206,405.00
December, 1932	1,258,672.00
January, 1933	1,331,825.00
February, 1933	1,234,741.00
March, 1933	1,271,784.00
April, 1933	1,284,895.00
May, 1933	1,342,120.00
June, 1933	1,333,867.00
July, 1933	1,290,472.00
August, 1933	1,310,558.00
September, 1933	1,283,945,000

Operating Expenditures

January, 1929	2,104,552.74
February, 1929	2,007,945.24
March, 1929	2,099,208.11



April, 1929	2,071,386.46
May, 1929	2,064,381.77
June, 1929	2,034,409.13
July, 1929	2,045,112.96
August, 1929	2,068,388.63
September, 1929	2,050,510.38
October, 1929	2,079,042.06
November, 1929	2,091,089.31
December, 1929	2,127,053.36
January, 1930	2,190,909.95
February, 1930	2,067,112.17
March, 1930	2,120,861.86
April, 1930	2,064,328.56
May, 1930	2,102,407.49
June, 1930	2,027,258.00
July, 1930	2,038,042.00
August, 1930	1,985,045.00
September, 1930	2,079,154.00
October, 1930	2,033,163.00
November, 1930	2,003,297.00
December, 1930	2,031,148.00
January, 1931	2,058,681.00
February, 1931	1,963,391.00
March, 1931	2,026,363.00
April, 1931	1,976,430.00
May, 1931	1,967,866.00
June, 1931	1,932,832.00
July, 1931	1,925,156.00
August, 1931	1,870,985.00
September, 1931	1,890,891.00
October, 1931	1,885,424.00
November, 1931	1,829,539.00
December, 1931	1,889,887.00
January, 1932	1,806,279.00
February, 1932	1,763,572.00
March, 1932	1,762,657.00
April, 1932	1,733,486.00
May, 1932	1,672,550.00
June, 1932	1,607,822.00
July, 1932	1,590,274.00
August, 1932	1,565,767.00
*September, 1932	1,508,519.00
*October, 1932	1,515,582.00
*November, 1932	1,488,989.00
December, 1932	1,568,845.00
January, 1933	1,546,747.00
February, 1933	1,490,075.00
March, 1933	1,585,755.00
April, 1933	1,531,870.00
May, 1933	1,536,710.00
June, 1933	1,545,307.00
July, 1933	1,555,554.00
August, 1933	1,555,701.00
September, 1933	1,579,869,000

Average Occupancy on 100 Per Cent Basis

January, 1929	71.6
February, 1929	73.8
March, 1929	73.2
April, 1929	72.2
May, 1929	71.2
June, 1929	71.3
July, 1929	67.8
August, 1929	67.5
September, 1929	65.0
October, 1929	68.0
November, 1929	68.6
December, 1929	64.0
January, 1930	70.1
February, 1930	72.1
March, 1930	71.8
April, 1930	70.0
May, 1930	69.4
June, 1930	66.6
July, 1930	64.7
August, 1930	62.7
September, 1930	62.8
October, 1930	62.9
November, 1930	62.4
December, 1930	59.1
January, 1931	64.9
February, 1931	67.5
March, 1931	67.2
April, 1931	65.8
May, 1931	63.0
June, 1931	62.6
July, 1931	60.3
August, 1931	59.7
September, 1931	58.3
October, 1931	59.0
November, 1931	57.5
December, 1931	56.8
January, 1932	60.2
February, 1932	61.8
March, 1932	61.0
April, 1932	59.3
May, 1932	56.4
June, 1932	55.6
July, 1932	53.6
August, 1932	54.6
*September, 1932	51.1
*October, 1932	51.6
*November, 1932	52.2
December, 1932	52.6
January, 1933	56.2
February, 1933	57.0
March, 1933	57.2
April, 1933	55.7
May, 1933	56.0
June, 1933	56.1
July, 1933	54.7
August, 1933	54.9
September, 1933	54.4

*One hospital closed during construction program.

Record Librarians Study Schools for Approval

THE schools for record librarians which have applied for approval by the Association of Record Librarians of North America are being studied by the organization, through its committee on training, and a decision is expected shortly. This action follows the convention in Chicago in October, the largest and most successful gathering in the history of the association and a meeting which sent visitors home inspired and encouraged.

Early action on the approval of schools is expected in view of the fact that registration of record librarians by the A. R. L. N. A. now may be had only by meeting the requirements adopted at the convention. The association set up procedure for conducting examinations by authorized representatives in centers near where the applicant lives. A total of 237 record librarians took advantage of the waiver rule up to September 1, it is announced.

Activities of the A. R. L. N. A. during the next twelve months are under the direction of the following officers and councillors:

Evelyn Vredenburg, Woman's Hospital, New York, president.
Edna K. Huffman, St. Luke's Hospital, Davenport, Ia., president-elect.
Lucille Neumeister, Finley Hospital, Dubuque, Ia., first vice president.
Helen Wheelock, Harper Hospital, Detroit, second vice president.
Councillors: Florence G. Babcock, University of Michigan Hospital, Ann Arbor; Jessie Harned, Rochester, N. Y., General Hospital; Sister Dominica, Charity Hospital, Cleveland; Maurine S. Wilson, Ravenswood Hospital, Chicago; Alice G. Kirkland, Merritt Hospital, Oakland, Calif.
Dorothy E. Fressle, St. Joseph Hospital, Chicago, corresponding secretary.
Cora Mecum, Duke Hospital, Durham, N. C., corresponding secretary.
Adeline Kennedy, Indiana University Hospitals, Indianapolis, treasurer.

Among those responsible for the outstanding conference in Chicago were the following committee chairmen:

Arrangements, Miss Fressle.
Program, Minnie V. Hill, California Hospital, Los Angeles, Calif.
Exhibits, Effie M. Barnholdt, Chicago, Memorial Hospital, Chicago.
Credentials, Gertrude Edelman, Jewish Hospital, Cincinnati, Ohio.
Nominating, Mary Newton, Pittsburgh Homeopathic Hospital, Pittsburgh, Pa.
Revision of By-Laws, Ellen Griffin, Cambridge Hospital, Cambridge, Mass.
Finance, Billie Haag, Memorial Hospital, Houston, Texas.
Membership, Mrs. Huffman.
Committee on Training of Librarians, Mrs. Harned.
Board of Registry, Edith Robbins, Peter Bent Brigham Hospital, Boston, Mass.
Registrar, Miss Vredenburg.

Miss Kirkland, who was in general charge of the 1933 convention, was named registrar for the ensuing year, and Dorothea Trotter, Blodget Memorial Hospital, Grand Rapids, Mich., is chairman of the board of registration.

The annual banquet, presided over by Robert Jolly, Memorial Hospital, Houston, Tex., was, as usual, a most enjoyable evening of informality and fun. It was in striking contrast to the busy days of meetings, at which the program as published in the last issue was followed with very few changes. Among the many things for which the 1933 conference in Chicago will be outstanding is the presentation to the A. R. L. N. A. of a silver banded gavel by the honorary president, Grace W. Myers, librarian emeritus, Massachusetts General Hospital, Boston.

NURSING SERVICE

[This material is taken from a series of mimeographed instructions governing nursing procedures of Columbia Hospital, Milwaukee, Wis. Other procedures appeared in previous issues, and additional instructions will be found in subsequent issues.]

Bed Shampoo

EQUIPMENT

One rubber pillow case.
One rubber half sheet.
One ether rubber.
One half sheet.
Two bath towels.
Two doctor's or face towels.
One wash cloth.
Basin with water, 110 degrees.
Soap solution.
Two pitchers rinsing water, 105 and 85 degrees.
Comb.
Cotton.
Safety pins.
Foot tub and stool.
Newspapers.

PROCEDURE

Preparation of bedside.—Carry all equipment to bedside. Spread newspapers on floor at head of bed. Place stool with tub half under bed near head, pitchers on floor, rest of equipment on table.

Preparation of patient.—Remove all pillows and replace one cotton case with rubber one and place under patient's head, using doctor's towels to protect head from rubber. Half sheet and rubber are slipped under pillow to protect mattress above draw sheet. Bring patient as near side of bed as possible, facing opposite side. Folded doctor's towel is pinned closely around patient's neck, and ether rubber over it with end directed into foot tub. Cotton is placed in the ears.

The shampoo.—The hair is wet, using the wash cloth, and the soap solution is then applied with the hand, massaging the scalp until a good lather is formed. The patient turns her face to the pillow so that the back and other side can be washed. When clean, the lather is removed with the wash cloth and the hair is then rinsed, used the warmer pitcher first. Care must be taken to direct the flow of the water toward the head of the patient and to rinse thoroughly. The head is then wrapped in a bath towel, and the ether sheet, doctor's towels and half sheet are removed. The hair is dried by squeezing (not wringing) in towel and by shaking out with hands, fanning and massaging. When nearly dry, a fresh bath towel is placed under the patient's head, the rubber pillow case removed and other pillow replaced. Hair is combed. Patient is left comfortable, furniture put in place and rest of equipment taken out.

Stupes

PURPOSE

To relieve post-operative distention, Tympanites of pneumonia, peritonitis, typhoid fever, deep seated pain, especially in the abdominal cavity.

EQUIPMENT

Blanket.
Half sheet and rubber protector.
Towel.
Stupe wringer.
Two pieces of flannel (16 by 11 inches).
Two pieces of sheet wadding large enough to cover abdomen.
Waxed paper.
Agate basin.
Large pitcher with boiling water.
Cotton ball applicator.
Medicine glass with cotton seed oil 2 drams to turpentine 1 dram.
Rectal tube and urinal if needed.

PREPARATION

Arrange materials on table in order of use. Turn back upper clothing to ptaient's waist line. The patient raises his arms on the pillow out of the way. Place small blanket, doubled, over body. Turn nightgown up over chest and draw upper bedclothing down to pubes. Under the patient insert half sheet and rubber inside the binder so that the half sheet is next to the patient. If the rectal tube is to be used, it is now inserted. Place a piece of sheet wadding large enough to cover the pa-

tient's abdomen over the turned back fold of bedclothing. Over the wadding the dressing towel is folded at one end and tucked over the edge of the upper bedclothing as a protective. On the towel is placed a second piece of wadding and the crumpled waxed paper.

The sticks of the wringer are slipped into place and the wringer spread over the basin. One of the stupes is inserted between the folds of the wringer. When all is ready a large pitcher of boiling hot water is carried to the bedside and poured over the contents of the wringer until saturated, when the sticks are grasped firmly, held as far apart as possible, and forcibly twisted in opposite directions until there is not a drop of water evident.

Application

Fold back the blanket sufficiently to expose the abdomen, saturate the absorbent cotton ball in a turpentine mixture and apply, starting at the umbilicus and covering the right and left upper and lower quadrants of the abdominal surface. Withdraw hot stupe from folds of wringer, shake out, place on back of both hands, and apply carefully to the patient. Cover at once with the sheet wadding and paper. Raise each end alternately a few times until the patient can bear the heat. Turn down the blanket over it and prepare another stupe before the first is removed. The interchange of the stupes is made quickly by turning the blanket back over the patient's chest and turning the sheet wadding and paper down together on the towel. The stupe on the patient is picked up in the center with one hand and placed upon the wringer, while at the same time the hot stupe is withdrawn from its folds with the other hand, and the backs of both hands, applied as in the first place.

Stuping may be kept up for fifteen to twenty minutes out of every hour.

After Care of Patient

At the end of each twenty minutes, the stupe, sheet wadding and paper are removed, and the abdomen gently patted dry with the dressing towel, which has served previously as a protector to bedclothing, and the abdomen is covered with the second piece of sheet of wadding. Remove half sheet and rubber. Adjust the binder and do not pin too snugly while distention is evident. Pull down nightgown, remove small blanket and readjust bedclothing. As an aid to abdominal relaxation and comfort of patient with distention, support the back of the thighs with a pillow.

After Care of Materials

The stupe wringer and sheet wadding are hung up to dry, ready to use again. The stuping flannels are washed in cold water, then in hot soapy water, after each treatment. The remainder of the turpentine mixture, if any, is tightly covered and used again for the same patient.

Notes

For children or old people use oil 2 drms. to turpentine ½ dram. The turpentine mixture should not be applied more than twice in twenty-four hours, to avoid blistering and the danger of absorption.

ILLINOIS COMMITTEES

Legislative—Paul Fesler, chairman, Wesley Memorial Hospital; Dr. Herman Smith, Michael Reese Hospital; Asa Bacon, Presbyterian Hospital; George S. Hoff, trustee, Lake View Hospital, Danville; Rev. M. J. Gruenewald, chancellor, Diocese of Belleville, Belleville; John C. Dinsmore, University Clinics.

Membership—Veronica Miller, chairman, Henrotin Hospital; J. Dewey Lutes, Ravenswood Hospital; Ralph M. Hueston, Silver Cross Hospital, Joliet; Macie N. Knapp, Brokaw Hospital, Normal; Margaret Arnold, Lake View Hospital, Danville.

Constitution and By-Laws—Rev. J. H. Bauernfeind, chairman, Lutheran Deaconess Hospital; Rev. G. A. Kienle, Evangelical Hospital; Mrs. Valentine R. Bosworth, Chicago Memorial Hospital; Howard E. Hodge, Decatur and Macon County Hospital, Decatur.

Auditing—E. E. Hanson, chairman, Lutheran Deaconess Hospital; Mr. Patterson, Paris Hospital, Paris; Ellen Stewart, Victory Memorial Hospital, Waukegan; Admiral N. J. Blackwood, Provident Hospital.

Nominating—J. W. Meyer, chairman, Copley Hospital, Aurora; L. C. Vonder Heidt, West Suburban Hospital, Oak Park; Dan Traner, Swedish American Hospital, Rockford.

Publicity and Arrangements—Matthew O. Foley, chairman, Hospital Management; R. C. Buerki, State of Wisconsin, General Hospital, Madison; J. C. Crownheart, Wisconsin Medical Society, Madison; Edward Rowlands, Martha Washington Hospital; A. G. Hahn, Deaconess Hospital, Evansville; M. T. MacEachern, American College of Surgeons; Clarence Baum; Maurice Dubin, Mount Sinai Hospital; Paul Fesler.

Program—Dr. M. T. MacEachern, chairman; E. I. Erickson, Superintendent, Augustana Hospital; Charles M. Wordell, St. Lukes Hospital; Matthew O. Foley; Maurice Dubin.

Efficiency, Economy in the Record Department

By Mabel E. Hayles
Record Librarian, Pasadena Hospital, Pasadena, Calif.

THAT every hospital, regardless of its size, its type or its location, is responsible for a good case record on each patient, is well known to all hospital workers. Clinical records reveal interest and progress in scientific medicine or they disclose a lack of it, and without good case records a hospital cannot be regarded as scientific.

We must have the wholehearted determination and cooperation of the medical staff, the superintendent of the hospital, and the nursing personnel to secure good histories, and a definite method of securing all the facts pertinent to the case.

Superficial methods are still used by some doctors in furnishing information on patient's past history or to record the physical findings, and it is because of this incomplete information that a record librarian has her greatest difficulty. In such cases it is necessary to have the unfailing support of her record committee. May I say that she is a fortunate record worker when the president of the medical staff confers with her in the appointment of his chart committee?

The bedside notes written by the attending nurse should convey the development, progress, and course of the disease during the patient's entire hospitalization, the nurse expressing herself as comprehensively as possible so as to be of valuable aid to the doctor in his diagnosis and treatment.

To have a model chart for all hospitals would be an impossibility, but one must adjust her method to the size and type of the hospital. It is not an easy matter to effect radical changes in systems of handling hospital records, but it is good business acumen periodically to check over the methods used to see whereby one can improve the caring for charts after all the clinical data on the individual cases are compiled.

The one handling these charts must see that all component parts are assembled, properly filed and indexed.

The indexing should include beside the identification of patient, diseases and diagnoses, associated diseases, secondary complications, operations and causes of death.

Because of the storage problems that keep facing all hospitals, where case records can be conveniently and safely kept, it is necessary to evolve a system of filing that is easy of access and that can be readily expanded. The unit system of filing seems to meet with the approval of most hospitals.

There seems always to have been an effort to keep the record department down to the least possible expense, but we as individuals feel the need of counting costs, so we must consider how we can keep up the maximum efficiency with the minimum amount of expenditure, ever mindful of the ideals of the American College of Surgeons when they made their standardization requirements.

Shall we not ask ourselves:

"Have we the proper forms on which to record our clinical data?

"Are we using many more forms, or much more stationery than is needed, thereby adding useless bulk to our records?

"Is our system too complicated, so that it entails too much time to assist in research?

"Are we requiring too much clerical work of the nurse?

"Are we duplicating statistics compiled in other departments that might be sent in to us quarterly, semi-annually or annually to be made a part of our records?

"And do the doctors cooperate sufficiently to reduce the time spent in preparing statistics?"

Let us through our organization cooperate in getting suggestions that will enable us to have an efficient and economic scientific record and legal document that will be a credit to our hospitals, to the members of our medical staffs, and to us all.

BOOK FOR RECORD LIBRARIANS

"Record Librarian's Manual," by Dr. Carl E. Black, has been published by the Bruce Publishing Company, St. Paul, price $2.00. This book should be of special interest to record librarians and to those intimately connected with the record department, since it has a section devoted to the general work of a record librarian and some general material that is original and practical. The major portion of the book is devoted to the Dewey Classification, which is used by the author and by the hospital with which he is associated.

THE HOSPITAL CALENDAR

Alberta Hospital Association, November.
Colorado Hospital Association, Denver, November 15-16.
Washington State Hospital Conference, Seattle, November 18.
Hospital Association of Rhode Island, Providence, December 7.
New England Hospital Association, Boston, February 16-17.
Ohio Hospital Association, Cincinnati, April, 1934.
American Hospital Association, Philadelphia, 1934.
Protestant Hospital Association, Philadelphia, 1934.

People and Products

By Kenneth C. Crain

Paul J. Cardinal, of Hoffman-LaRoche, Inc., who lives not far from that famous company's fine plant in Nutley, N. J., is receiving the well-deserved congratulations of his friends on the recent birth of a son. Mr. Cardinal is the father of two fine young daughters, and feels that the new arrival makes things just about complete. Hospital friends who at the Milwaukee convention pointed out that the law of averages indicated a boy are now pluming themselves on their mathematical ability.

Carroll Adams, who in the past few years has become an expert moving-picture operator and exhibitor in handling the Davis & Geck contributions to numerous hospital and medical conventions, was especially busy at the recent College of Surgeons meeting in Chicago, as he ran supplementary showings of some of the new films in his room to enable interested surgeons to note technique more closely and at leisure. Mr. Adams happens to be especially proud of the new D. & G. tonsil suture, utilizing an eyeless needle which tends to reduce trauma materially.

A recent addition to the staff of an organization whose products have been for some years widely known in the hospital field, S. Gumpert Co., is Robert Gumpert Janover, son of D. W. Janover, president of the company. Young Janover is a Cornell graduate at the early age of 20, having finished the four-year course in three years, and he is going through the basic departments of the company's plant in Brooklyn, N. Y., as the best start in familiarizing himself with the business.

A visit to the big plant of F. C. Huyck & Sons, just across the river from Albany, N. Y., produces many things of interest to hospital people as well as to the general public. One of the features sure to hold the attention is the store in which the firm's products are displayed for retail sale, and here those who think only of good blankets in connection with the famous Kenwood trade-name may be surprised to find not only blankets, but a wide variety of other wool products. Rugs especially designed for hospital use, robes and heavy woollen sleeping suits, and suits and overcoats patterned in tweeds and mixtures equal to the best from Scotland, are among the items shown.

Hospital people have become so used to receiving and enjoying the friendly, human and humorous monthly letters of Will Ross that if these should for any reason stop coming they would undoubtedly leave a vast void. These letters, which it is generally suspected are the work of Mr. Ross himself and not of any mere paid advertising man, are usually almost without any apparent business angle. They only mention business casually, as in the case of the Nov. 1 letter, which explained that the rapidly changing price situation has made it impossible to issue the annual catalog in November, as usual, and that the 1933 book should therefore be used a while longer. Those who attended the enormously successful exhibitors' party at Milwaukee recall how much Will Ross was responsible for it, and accepted it as another proof of his versatility.

Some unusually interesting information about matters of everyday concern to hospital executives is offered in advertising in this and the previous issues of HOSPITAL MANAGEMENT. Among these are the following:

The Onondaga Pottery Co. offers details about a new idea in china designed to save table and tray space.

The Massillon Rubber Co. offers a free sample pair of dermatized rubber gloves.

Lehn & Fink have details of a new yearly purchase plan for "Lysol."

The Johnson Service Co. suggests a no-charge survey of heating and air-conditioning equipment by their engineers.

For a limited time only . . . . this $15 book

$7.50

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Fellow of American Institute of Architects—Member of American Hospital Association

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"The American Hospital of the Twentieth Century" presents in a concrete form a vast fund of correlated facts, dealing with a number of Hospitals of international fame.

Mr. Edward F. Stevens, of Boston, is known in Europe and America as an authority on Hospital construction and equipment. He has approached his subject from a practical standpoint, selecting with discrimination and discussing in full detail.

This new edition has been entirely rewritten and much new material has been added. It discusses many departments, including the Kitchen and Laundry, devotes special chapters to Heating, Ventilation and Plumbing—Details of Construction and Finish Equip ment—Landscape Architecture as applied to Hospitals, etc., etc.

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Street Address.... .....

City and State..... ...

STATEMENT OF THE OWNERSHIP, MANAGEMENT, CIRCULATION, ETC., REQUIRED BY THE ACT OF CONGRESS OF AUGUST 24, 1912

Of Hospital Management, published monthly at Chicago, Illinois, for October 1, 1933.

State of Illinois, County of Cook, ss.

Before me, a Notary Public in and for the State and county aforesaid, personally appeared Matthew O. Foley, who, having been duly sworn according to law, deposes and says that he is the Editor of the Hospital Management and that the following is, to the best of his knowledge and belief, a true statement of the ownership, management (and if a daily paper the circulation), etc., of the aforesaid publication for the date shown in the above caption, required by the Act of August 24, 1912, embodied in section 411, Postal Laws and Regulations, printed on the reverse of this form, to wit:

1. That the names and addresses of the publisher, editor, managing editor, and business managers are:

Publisher, Crain Publishing Co. (a partnership), Chicago, Illinois; Editor, Matthew O. Foley, Chicago, Illinois; Managing Editor, None; Business Manager, Kenneth C. Crain, Chicago, Ill.

2. That the owner is: (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding one per cent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a firm, company, or other unincorporated concern, its name and address, as well as those of each individual member, must be given.) Crain Publishing Co. (a partnership), 537 S. Dearborn St., Chicago, Ill.; Kenneth C. Crain, 537 S. Dearborn St., Chicago, Ill.; Matthew O. Foley, 537 S. Dearborn St., Chicago, Ill.

3. That the known bondholders, mortgagees, and other security holders owning or holding 1 per cent or more of total amount of bonds, mortgages, or other securities are: (If there are none, so state). None.

4. That the two paragraphs next above, giving the names of the owners, stockholders, and security holders, if any, contain not only the list of stockholders and security holders as they appear upon the books of the company but also, in cases where the stockholder or security holder appears upon the books of the company as trustee or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting, is given; also that the said two paragraphs contain statements embracing affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner; and this affiant has no reason to believe that any other person, association, or corporation has any interest direct or indirect in the said stock, bonds, or other securities than as so stated by him.

5. That the average number of copies of each issue of this publication sold or distributed, through the mails or otherwise, to paid subscribers during the six months preceding the date shown above is..... (This information is required from daily publications only.)

(Signature) MATTHEW O. FOLEY.

Sworn to and subscribed before me this 20th day of September, 1933.

ELLEN KEBBY.

[SEAL]

(My commission expires Apr., 1935.)

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(A) PROTESTANT, with post-graduate course and experience to supervise surgery 150-bed general hospital vicinity Chicago. $100, maintenance.

(B)—MALE OPERATING ROOM SUPERVISOR, for active surgical department large prison hospital. Post-graduate training required.

(C)—ASSISTANT OPERATING ROOM NURSE, eligible Ohio registration, for large metropolitan hospital; post-graduate course necessary. Protestant, about 30 years old, preferred. $75, maintenance.

(D)—SURGICAL NURSE to act as assistant to surgeon; some knowledge laboratory work desirable. Salary open. 5170

EXECUTIVE AND TEACHING APPOINTMENTS:
(A)—ASSISTANT SUPERINTENDENT NURSES, with training psychiatric nursing and teaching experience for 2,000-bed mental hospital, East. $105, maintenance.

(B)—SUPERINTENDENT OF NURSES, about 35 or 40 years, for approved 130-bed hospital, large midwestern city. Prefer college-trained nurse. $150-$200.

(C)—EDUCATIONAL DIRECTOR, obstetrical unit University Hospital. Must have degree, post-graduate training and at least five years' experience in obstetrics. $150 to start.

(D)—INSTRUCTRESS, both theory and practice, for ACS and AMA approved hospital, teaching 60 students. Must be Catholic between 30 and 35 years old. Large southern city.

(E)—PRACTICAL INSTRUCTRESS, Ohio registered, for large mental hospital. Psychiatric nursing experience required. Salary open.

(F)—SUPERINTENDENT OF NURSES, 40-bed ACS approved hospital, large Ohio city. Must give Anesthetics. 5171

ANESTHETISTS: (A) Anesthetist for 80-bed hospital near Boston. Must assist with X-ray. $120, maintenance. (B) Anesthetist for dentist's office, East; must have office experience. Typing required. Good salary. 5172

NURSE-TECHNICIANS: (A) Office nurse, to do routine laboratory and X-ray for office southern surgeon; $75, maintenance. (B) Michigan registered nurse, able to do both laboratory and X-ray for 24-bed hospital, northern part of state. Salary open. (C) Nurse-Laboratorian for leading clinic, midwestern university city. Salary open. 5173

MISCELLANEOUS APPOINTMENTS:

(A)—ASSISTANT SOCIAL SERVICE WORKER, able to type, for 300-bed hospital eastern resort city. $60, maintenance.

(B)—COLLEGE NURSE, southwest; maintenance and tuition fees offered in exchange for part-time service in student health work. Excellent opportunity for nurse desiring to secure degree.

(C)—NURSE-DIETITIAN for excellent clinic hospital; act as dietitian for small hospital unit and assistant to Internist of the group. Large eastern city.

(D)—SUPERVISOR with special training in both contagious diseases and obstetrics, for isolation unit large maternity hospital. Must be experienced executive. 5174

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The Medical Bureau is organized to assist physicians, dentists, graduate nurses, hospital executives, laboratory technicians and dietitians in securing positions; application on request. tf

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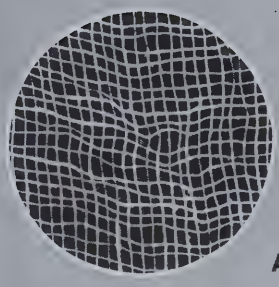

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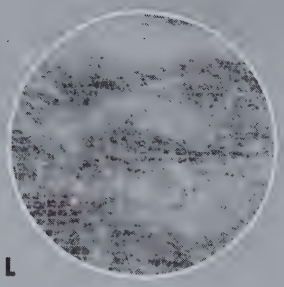

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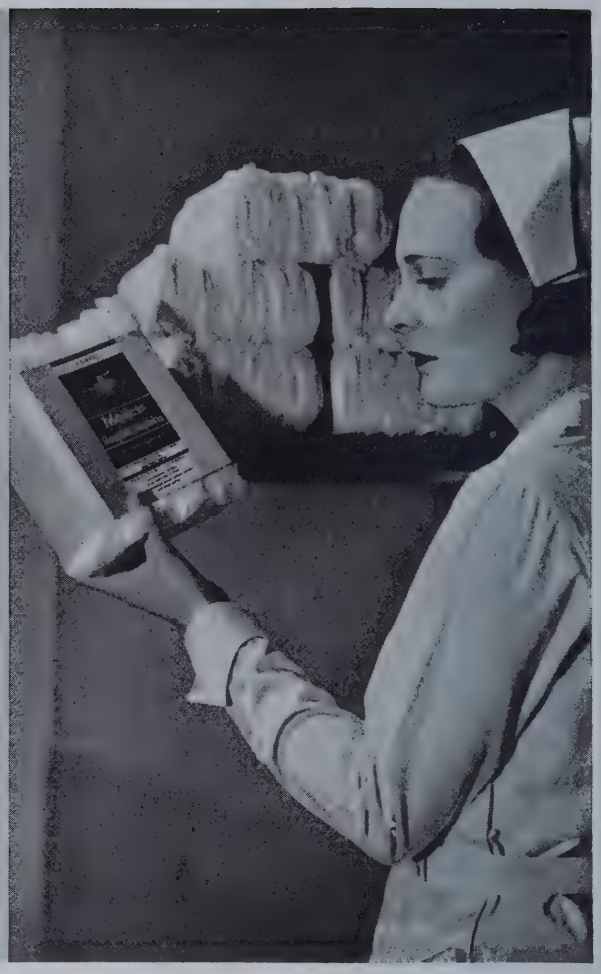

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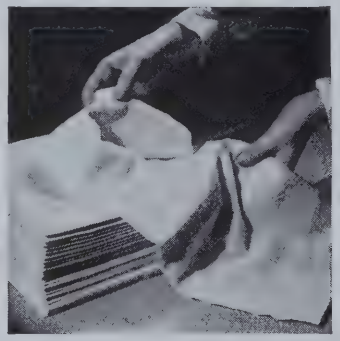

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Hospital Management

A Practical Journal of Administration

OCTOBER 15, 1933

VOLUME XXXVI—NUMBER 4

¶ *How to Get 94.2 Percent Autopsies* ¶ *138 "Graduates" of First A. H. A. Institute* ¶ *How to Borrow for Hospital Construction From U. S.* ¶ *2,384 Names on 1933 A. C. S. Approved List* ¶ *How Much Are You Wasting on Nourishments?* ¶ *Group Hospitalization Broadened to Employe's Family* ¶ *How to Figure Laundry Costs.*

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HOSPITAL MANAGEMENT

A Practical Journal of Administration

CONTENTS FOR OCTOBER

EVERY-MONTH FEATURES

BUYERS' GUIDE PAGE 4; INDEX TO ADVERTISERS PAGE 7

VOLUME XXXVI, NUMBER 4 OCTOBER 15, 1933

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INDEX TO ADVERTISERS

Some Letters to the Editor

This month's letters are comments from students who attended the Institute in Chicago conducted under the auspices of the American Hospital Association and other organizations.

LEE C. GAMMILL, superintendent, Baptist State Hospital, Little Rock, Ark.: "We consulted with consultants, listened learnedly at architects, and, by the way, we all learned that there is lots of similarity between doctors and architects—both reserve plenty of loop holes to escape. The statisticians were good and convinced us, and the seminars nearly loosened the tongues of hospital executives.

"The wordy highlights were 'generic,' 'repercussion' and 'minutiae'—even I can use them now.

"The Chicago Hospital Association was more than host, and the hospitals made every sacrifice for our clinic instruction as well as teas. You should have seen the face of a directress of nurses at a tea of one of the wealthier hospitals, when she announced that coffee was served on the left and tea on the right, and someone wise-cracked that they had invited him to tea and that he would drink the stuff if it killed him.

"Our Canadian cousins were of great interest and benefit to the success of the institute. By the way, we located a successor for Jolly as a round tabler. We all talked for Buerki.

"I only intended to stay long enough to see what Drs. Caldwell and MacEachern had started and visit A Century of Progress. The institute was so worth while that I most forgot the Fair and coming home. Also, my wife had mentioned a trip by motor we were to take on my vacation. After I had overstayed one week I realized that my punishment would be severe. I stayed an additional week and it worked—she was glad to see me. So I am faring fine, much knowledge gained and benefit secured, my expense account settled, my wife still glad to see me, again ambitious, correspondence current, and my hospital functioning perfectly. All that is left is trying to read the book of notes taken. I wish that I had spent the $7.50 for a copy of the proceedings.

"My very personal and sincere appreciation goes to the instigators of the institute, each lecturer, all Chicago hospitals, their association, and especially to the director of University of Chicago Clinics and his man-hating but efficient secretary.

"The university atmosphere was appreciated but not the fact that I was quartered next to the football squad. However, it must have been an honor as I paid extra for it.

"It was realized by the majority of us in attendance that hospital administration history was being made and a long felt need being supplied. The more than 200 attending signified acute interest. It is sincerely hoped that from this institute will come a movement to furnish adequate instructions to the old as well as new hospital executive."

CHARLES H. DABBS, Tuomey Hospital, Sumter, S. C.: "It has truly been a most pleasant and profitable experience and not the least in value is the intimate and lasting friendships which have resulted from the close association of the classroom and in the 'homey' atmosphere of the college dormitories.

"The course must be regarded by all as distinctly beneficial.

"The unexpectedly large attendance undoubtedly made for difficulties or minor disappointments on the part of both the student and faculty.

"More important perhaps than any of the immediate benefits gained, at least to the field at large, is the precedent which has been established."

L. M. TEFFEAU, Michigan Masonic Home, Alma, Mich.: "When one considers that colleges have attempted work in hospital administration, and apparently failed, we naturally expect that if it can be done successfully that the American Hospital Association will lead the way. Certainly the method of approach and the manner of presentation are entirely different, and for the first time one finds even with experience that the subjects are growing more interesting. I am keenly interested in knowing what an extra week or two would mean for those who would be willing to stay? I am glad to have spent the time and would even be interested in a yearly institute."

HAZEL BENNETT, Shaw Clinic and Hospital, Marlin, Texas: "I had no idea a three weeks' course could be so extensive. Everything from the front door of the hospital to the garbage can has been discussed."

HELEN T. NIVISON, Griffin Hospital, Derby, Conn., and FRANCES P. WEST, Middlesex Hospital, Middletown, Conn.: "It fills a long existing need for hospital administrators and its real benefits will be proved in the future of our hospitals."

H. CHESTER LARRABEE, assistant superintendent, Binghamton, N. Y., City Hospital: "Like A Century of Progress, the Institute has been a remarkable success. The splendid spirit of cooperation of the various associations and the courtesies extended by the University of Chicago and the Chicago hospitals made the Institute very interesting."

MRS. Z. V. CONYERS, Sternberger Children's Hospital, Greensboro, N. C.: 'The Institute has been perfect. I hope this movement is permanent and that I will have the pleasure of enrolling next year."

E. A. JACOBS, assistant director, St. Luke's and Children's Hospital, Philadelphia: "I noticed that a large percentage of the student body was composed of persons holding positions of a subordinate nature. I think they should have been segregated from the more seasoned administrators. Much time has been wasted on elementary questions. Furthermore, they would have derived greater benefits from the institute had they been segregated. The executives from smaller hospitals should have been separated from those representing the larger institutions.

"The curriculum committee is to be congratulated for the fine performance of its work. However, it should have exercised greater care in the selection of the men who conducted the seminars. Several made a few of the seminars extremely montonous. I realize that their administrative ability is beyond reproach; nevertheless, they lacked the pedagogic ability to impart the knowledge.

"I should like to add a word of praise. The institute has been very inspiring, more so than a convention because of the intimacy of a small group of people. I feel that I shall return to my job with a higher regard for its responsibilities and a better understanding of the proper performance of my duties. I have gathered many ideas for increased efficiency throughout my entire organization.

"The hospitals of Chicago deserve a vote of thanks for their excellent cooperation. And last but not least, I think everyone appreciates the many courtesies of Miss Brannan."

MARY G. MCPHERSON, Ellis Hospital, Schenectady, N. Y.: "The Institute has given us a yardstick with which to measure our past activities. Great inspiration has been gained from Dr. Davis, Dr. Rorem, Dean Spencer, and much stimulation from the excellent clinics of Mr. Bacon, Mr. Fesler and all of the seminar leaders. We appreciated the privilege of using the beautiful residence halls, and all that Mr Dinsmore and Miss Brannan, his valuable secretary, have done. We are going back full of new ideas and endeavor to do more.

"The Chicago Hospital Association has been a wonderful example to us of real cooperation. The work of entertainment and arrangement has never been done better.

"It seems that the Institute, in bringing together more than 175 administrators in an honest effort to give better hospital service to their communities, has been an example of the century's progress."

CAROLYN M. FENBY, Methodist Hospital, Madison, Wis.: "I feel the A. H. A. should be commended for the educational program it has conducted. The program as outlined with its lectures, seminars and clinics has made the course especially profitable and interesting. I am sure the principles of hospital organization and administration have been indelibly fixed in our minds."

V. RAY ALEXANDER, St. Louis, Mo.: "The remarkable attendance, with international aspects, was an indication that there was a justifiable demand for some such exchange of ideas and experience. It was the consensus of 'students' that the course was invaluable."

HELEN M. BLAISDELL, Westerly, R. I., Hospital: "The Institute was very satisfactory. I derived much benefit from the lectures, seminars and clinics. The association with other hospital administrators has been most stimulating. My only criticism would be to correlate lectures and clinic material more closely."

JESSIE P. ALLAN, Kingston Hospital, Kingston, N. Y.: "The program was such a full one that there was difficulty in deciding which session to attend. The variety of subjects presented gave ample material for the large number who availed themselves of the opportunity given by the A. H. A. The Chicago Hospital Association proved a charming host with the delightful quarters provided by the University of Chicago, a very enjoyable and profitable three weeks passed all too quickly."

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What Members of the Editorial Board Have to Say About:

Highlights of the Recent Convention of the A. H A.

AT the A. H. A. convention, I liked the fine convention and meeting halls, where there was ample space for the different sectional meetings.

Dr. Caldwell, the Milwaukee committee of which Rev. H. L. Fritschel was chairman, and the exhibitors' committee are to be congratulated on the fine arrangements.

The section meetings were excellent, but with the exception of round table meetings there was no time for general discussion. I suggest that fifteen minutes of each section meeting be allotted for general discussion from the floor.

The educational and commercial exhibits were well arranged and diversified and worth the cost of the trip.

I have been attending American Hospital Association conventions since 1912 and do not recall a better one than 1933.—C. S. PITCHER.

■

I LIKED Dr. Goldwater's paper, "The Hospital Corridor."

My suggestion for a more interesting convention would be to have fewer papers and more round tables.

In regard to the exposition of supplies and equipment, I did not spend much time at the booths, because there was too much smoke. I would suggest that exhibitors refrain from smoking at least while exhibiting their wares.

It was a splendid convention, one of the best I have ever attended.—HARRIET S. HARTRY.

■

THE recent convention of the American Hospital Association was in my opinion a decided success. The exhibition was splendid and the exhibitors were cooperative, helpful, and most patient with those with whom they came in contact. The program in my judgment was very well arranged, and covered the topics that were most important to all types of hospitals.

I think that Dr. Caldwell should be congratulated on the excellency of the programs and on the demonstrations of the various exhibitions, and on the smoothness with which the entire convention moved along.—WALTER E. LIST, M. D.

■

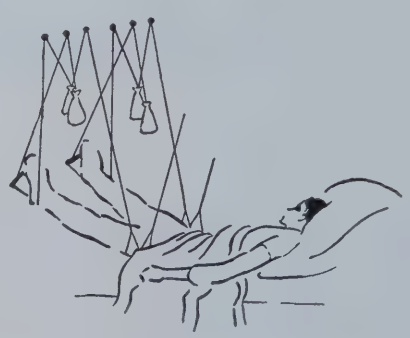
IN regard to the convention: There did not seem to be so many new ideas presented in exhibits this year as in the past, due no doubt to the stringent times.

Having the exhibits on separate floors was unfortunate for the exhibitors. Folks like to be with the crowd.

Several commented on the excellent eating place in the convention hall, which gave them a chance to visit with their friends and also attend the displays between meetings.

Meeting the exhibitors and executives from other hospitals gives one an opportunity to make his own round table. Comparing notes with other hospital directors helps solve problems pertinent to your own institution. I find this always a high spot in all conventions.

Some of the older hospital directors suggested that the papers were too long. They thought that there were too many rudimentary details given and did not give enough time for discussion. I feel that the chairman should insist on a time limit to papers and the authors should prepare with this in view.—CLARENCE H. BAUM.



■

I THINK the meeting at Milwaukee was the best we have ever had because of the free exchange of ideas at the round tables. I think the round table conferences are much more interesting and add a great deal to the meeting.

I would not want to make suggestions relative to the conduct of the convention. I think that the Council's plan to carry on things in a regular systematic manner from year to year will improve the work of the convention for the future.

I think that the educational exhibits were very worth while and give a very good view of the progress in hospital care and would be of exceptional value if they could be shown to the public.—PAUL H. FESLER.

■

A SPIRIT of determination and courage seemed to me to characterize the Milwaukee convention. There was an earnest search for truth which would be of service in the conduct of our institutions. I was also impressed that there was a greater degree of patience in the meetings than I have ever observed.

I believe that there is too much repetition of subjects. Special effort should be made to present only new material or mold material in a new light. Perhaps it would be well to reduce the number of days of the convention.

I think it is true that all of the exhibits were interesting and worth seeing. The new equipment, the new books, the new methods, all engaged the attention of everyone who appreciates that these are indispensable in our daily work.—C. S. WOODS, M. D.

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* * *

Lower dishwashing costs per thousand pieces,—that's what you're looking for, isn't it? And that can't be accomplished by looking for the lowest priced dishwashing powder. Lower costs are, however, definitely guaranteed to the users of Wyandotte Cherokee cleaner for machine dishwashing, and that means lower costs per thousand dishes. Cherokee Cleaner is all active cleaner. It contains no filler. It cleans thoroughly, rinses freely, and protects your dishes from brown stains. Page 11.

* * *

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* * *

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* * *

A combination of art and science is required to have each batch of Bay-Hesive conform with set standards. That it does conform is evidenced by tests that determine its ability to reach maximum tenacity at body temperature—and by critical check-up and examination to insure uniformity of thickness and appearance as well. You can test different makes of plaster by placing them on glass with a light below. The light shining through will disclose imperfections if they exist. Dark spots denote an improper mixture of the adhesive mass while streaks reveal an uneven spread of the compound. HayHesive is uniformly clean. Page 2.

The Nursery Name Necklace alone is considered by the greater number of its hospital users to be infallible. Some hospitals, however, desire to identify and re-identify, so they combine two or three methods—and in nearly every instance the necklace is the main unit of their combinations. The mother can understand these "name-on-beads" at a glance. It is sealed on her baby at birth, never to be removed until she, herself, cuts it off. Page 57.

* * *

Tamblyn and Brown, Inc., offers its services to any group or committee which is contemplating the establishment of a program for group hospitalization. To this new and promising field of hospital financing the corporation brings the results of a special study of the subject and the experience and technical ability accumulated in thirteen years of counsel and guidance in fund-raising enterprises for hospitals in every part of the United States. Page 60.

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* * *

Monel Metal equipment stands the gaff of hospital use as no other equipment can. Write and ask us about Monel Metal's performance in other hospitals. . . not only in food service departments, but in clinical and laundry use as well. Insert facing page 53.

* * *

For several years practitioners in the medical and hospital field have become increasingly aware of the banana's importance as an aid to health. Very recently a review of the contributions which the banana makes to the diet has been published from the laboratory of a famous eastern university under the title of "The Nutritive Value of the Banana." Page 57.

Alcohol and its products play an important role in the hospital. Therefore, to the quality of the product the manufacturers must add the incidental helpfulness which derives from a sympathetic understanding of the ideals and needs of institutions devoted to the care of the sick. Today the Rossville Commercial Alcohol Corporation, through its recent affiliation with Commercial Solvents Corporation and the American Solvents and Chemical Corporation, finds itself in a greatly improved position to cooperate, within the field of its activities, toward perfection of hospitalization. Page 16.

* * *

A suture's tensile strength and absorption characteristics depend among other things on the ultimate structure of the catgut itself. Two apparently similar catgut strands may be structurally different. Even the most powerful microscope cannot reveal this difference! Curity now reveals this hitherto unknown quantity in catgut through the use of the most powerful eye avaible to man—X-ray! Through the means of X-ray diffraction technique, the Curity laboratories can observe the structural pattern of catgut. From this pattern can be definitely predicted the tensile strength and absorption tendencies of the catgut to a degree and with a certainty never before possible. Fourth cover.

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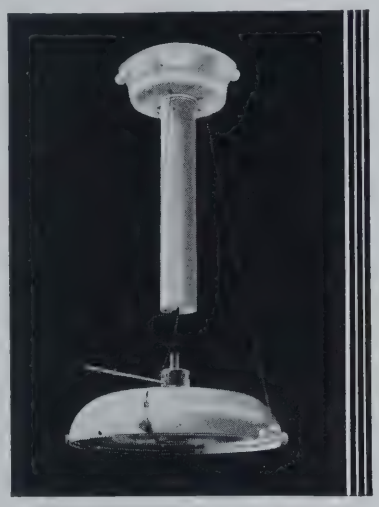

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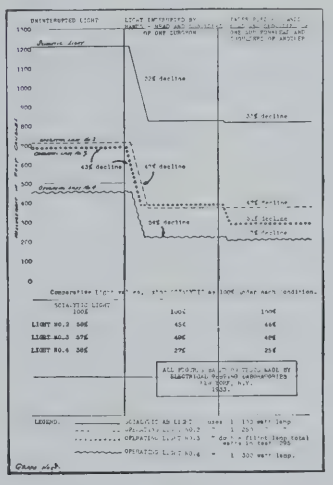

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How to Obtain 94.2% Autopsies

St. Luke's Hospital, Kansas City, Depends on Enthusiasm and Continued Encouragement of Pathologist, and Persistence of Interns to Achieve Remarkable Record

By JOHN R. SMILEY

Superintendent, St. Luke's Hospital, Kansas City, Mo.

St. Luke's Hospital, Kansas City, Mo., is the "champion" community type hospital in the country when it comes to obtaining permission for autopsy, according to the American Medical Association. In 1932 this hospital had a percentage of 94.2 per cent, leading all community type institutions and being surpassed by only one other hospital, a U. S. Public Health Service Hospital. Here's how that record was made, as told by the superintendent of St. Luke's Hospital.

AN efficient hospital procedure in the securing of autopsies is one of gradual development, the guidance of which is centered in one responsible individual, preferably the pathologist, who should have sufficient training and personality to command the enthusiastic cooperation and respect of the staff.

St. Luke's Hospital is a church hospital, operated as a non-profit institution, but has to depend on pay patients for support. Approximately 15 per cent of our patients are charity. Our only affiliation with a university is that a number of the Kansas University teaching staff are members of our hospital staff and do their private work in St. Luke's.

There has been built up in St. Luke's Hospital by our pathologist a procedure which in five years has raised our percentage of autopsies from 15 per cent to between 90 and 95 per cent. An outline of this procedure is as follows:

First, inasmuch as we have found from actual experience that over 95 per cent of all autopsies are secured by interns, we have established a custom of having a meeting on the first day of their intern service, at which time the pathologist outlines the laboratory service, emphasizing as forcibly as possible the importance of securing permission to do a complete autopsy on all patients. He outlines various methods of approach to relatives, and stresses the importance of selecting the member of the family most likely to be sympathetic to their request. They are then given various reasons or arguments to present to the relatives as to why an autopsy is desired. These arguments are based on the genuine and valuable contribution that the autopsy will make to science; the value it will be to the family in case of hereditary diseases; in cases of death by accident, the benefits to the family of the definite findings of the cause of death, both from a legal and insurance standpoint. In communicable diseases, the protection of the family and friends, and other arguments to be applied to individual cases. For example, in the death of Jewish patients, the relatives are informed that two leading Rabbis of the east have ruled that there is nothing in the faith against such a procedure, and we have very little difficulty in securing these autopsies. These and other general and specific instructions give the interns confidence in making their approach.

The pathologist then quotes the record made by the previous groups of interns, and expresses the wish that the new group will exceed last year's record. By dwelling on this he creates a spirit of competition, both with last year's group and among the interns themselves, to a degree that they are keenly disappointed when they fail to secure the permission and come to feel that a case history of a deceased patient is not complete without an autopsy report.

The pathologist maintains the interest created by his talk the first day the interns come to the hospital with a daily and nightly check-up on all dangerously ill patients with the intern on the service, and takes a clinical interest in the patient. By doing the autopsy within one hour after the patient dies, either day or night, and by notifying all interns and the attending physician that an autopsy is to be done, and during the autopsy explaining the symptoms by the pathological findings, discussing the

The 20 Leading Hospitals of U.S. In Percentage of Autopsies

AT the 1933 convention of the American Hospital Association, the American Medical Association displayed a chart showing the twenty hospitals with the highest percentage of autopsies for the year 1932. The following is the list.

It is to be remembered that Federal hospitals and state university hospitals serving free patients have an advantage over community type hospitals in the matter of obtaining permission for autopsies, and thus the six community type hospitals listed deserve proportionately much more credit for the splendid showing that they have made.

U. S. Marine Hospital, Galveston, Tex.	96.7
St. Luke's Hospital, Kansas City, Mo.	94.2
Bell Memorial Hospital, Kansas City, Kan.	88.7
U. S. Naval Hospital, San Diego, Calif.	83.3
U. S. Naval Hospital, Bremerton, Wash.	81.4
Johns Hopkins Hospital, Baltimore, Md.	81.0
Columbus Hospital, Chicago	80.4
University of Chicago Clinics	78.3
St. Luke's Hospital, Spokane, Wash.	78.1
Research and Educational Hospital, Chicago	75.1
Santa Fe Coast Lines Hospital, Los Angeles	75.0
University of California Hospital, San Francisco	74.7
St. Joseph's Hospital, Kansas City, Mo.	74.5
U. S. Naval Hospital, Mare Island, Calif.	74.4
Station Hospital, U. S. A., San Antonio, Tex.	73.1
Colorado General Hospital, Denver	73.0
University of Minnesota Hospitals, Minneapolis	72.3
St. Margaret's Hospital, Kansas City, Kan.	72.0
Duke University Hospital, Durham, N. C.	71.6
Mt. Sinai Hospital, Philadelphia	71.1

case history and any errors in the clinical diagnosis and the reasons for those errors, the interest of the staff has been greatly augmented. They lend their active cooperation to the extent of coming to the hospital at any time to add their request to that of the intern for permission to examine the body in case the intern is not successful. They are moved to do this because of the interesting and complete protocol that is prepared by the pathologist, and the instructive manner in which the case is presented by him at the monthly staff meeting, with the result of an increased attendance at these meetings.

To add to the interest of the attending staff, the hospital offers them a free outpatient autopsy service, whereby the pathologist will post any of their patients who die in the home, many of whom have been former patients in the hospital. This is appreciated by the staff, as is evidenced by the fact that we have done 41 such autopsies since January 1, 1933.

I trust the briefness of this discussion will emphasize the few points mentioned, and, as a conclusive argument, that the system works. I quote the statistics of our hospital on deaths and autopsies from January 1, 1932, to Dec. 31, 1932:

Deaths, 121; autopsies, 114; percentage, 94.2, which is the highest percentage secured to date.

We wish to emphasize the following points:

1. *A capable, well trained pathologist who is consistently interested in post mortem work.*
2. *Interns thoroughly instructed at the beginning of their service.*
3. *That interns are expected to procure over 95 per cent of permits.*
4. *That interns' interest must be maintained by constant encouragement by pathologist and staff.*
5. *That all autopsies be used for instruction purposes.*
6. *That all scientific and other information be utilized to the fullest extent.*

Group Service O. K. In Ohio

"Under date of September 26 the Attorney General of Ohio rendered an opinion to the Superintendent of Insurance declaring Group Hospitalization as proposed by the Cleveland Hospital Council and the Ohio Hospital Association to be exempt from the insurance laws of Ohio," says the bulletin of the Ohio Hospital Association. "His decision is as follows:

I am of the opinion therefore that, by virtue of the provisions of Section 669 of the General Code, none of the laws of this state regulating or pertaining to insurance applies to contracts for the furnishing of hospital service to the general public, individuals or groups, for a certain stipulated charge per year, so long as such contracts are made only with persons for whom such service is to be rendered who are residents of the county where the hospitals or sanatoriums in which such service is to be furnished are located.

"It is interesting to note that Section 669 referred to in the above was passed by the General Assembly April 23, 1904. We may think we have something new in Group Hospitalization, but apparently someone anticipated this twenty-nine years ago. We are attempting to get the story of the motive back of this legislation at that time and will give it to you if it is obtainable.

"Section 669 is as follows:

No law of this state pertaining to insurance shall be construed to apply to the establishment and maintenance by individuals, associations or corporations, of sanatoriums or hospitals for the reception and care of patients for the medical, surgical or hygienic treatment of any and all diseases, or for the instruction of nurses in the care and treatment of diseases and in hygiene, or for any and all such purposes, nor to the furnishing of any or all services, care or instruction in or in connection with any such institution, under or by virtue of any contract made for such purposes, with residents of the county in which such sanatorium or hospital is located.

"J. R. Mannix, chairman of the Ohio Hospital Association committee on group hospitalization, will have definite recommendations in the very near future for your guidance in the development of group hospitalization plans."

BEG YOUR PARDON!

HOSPITAL MANAGEMENT sincerely regrets that in reporting the officers of the Protestant Hospital Association an error was made in the name of one of the trustees. The new trustee is Carolyn E. Davis, superintendent, Good Samaritan Hospital, Portland, Ore. Miss Davis thus enjoys the distinction of being a trustee of two national associations, as she also is a trustee of the American Hospital Association.

A.H.A. Institute Proves Outstanding Success in Chicago

By MATTHEW O. FOLEY

WITH a registration of 200 the first institute of hospital administration sponsored by the American Hospital Association with the cooperation of various other groups and with the help of the University of Chicago proved an outstanding success. It was held September 18-October 6 in Chicago. Registration not only was much larger than had been expected, but it was representative of the entire continent, from Saskatchewan to Mexico City and from California to New Brunswick.

The experience of the personnel of the University of Chicago and the facilities of beautiful and spacious Judson Court were required to register, house, feed and complete the schedules of the students, and without this expert help and the physical resources of this unit of the university the institute would have not been nearly so pleasant and profitable as it proved to be.

The best indication of the general feeling of the students was reflected in the oft-repeated declaration that "I hope to be able to come again next year and I am sure this will be an annual affair from now on."

The general program of the institute began daily with a lecture attended by the entire student body. Following this there was a seminar in which questions designed to apply the principles and statements of the lecture to individual hospital problems were discussed. Then the students had lunch in the dining room of Judson Court. In the afternoon various Chicago hospitals, selected for the character of work done in different departments, were visited by groups of the students interested in specific subjects.

Sometimes the morning session was given over to a series of lectures, and at times it was difficult for students to choose between two talks of special interest to them.

At all times the presence of the students at the different lectures was controlled by attendance cards, and there was rigid insistence on this attendance, in order to qualify for the certificate of attendance which the association offered to those who fulfilled their obligations in this respect.

The final day began with a reconciliation program, conducted by the students. The committee appointed for this program and for the "graduation exercises" included Mr. Lacy, Dr. Leone, Dr. Ward, Miss Jamieson, Sister Reginald and Miss Hindman. Students chosen to speak for the group regarding the institute included Miss McPherson, Mr. Jones, Mr. Dent, Mr. Dabbs, Sister Reginald and Miss Jamieson.

The spirit of good fellowship which was engendered by the three weeks' association of the students in residence at Judson Court was reflected at the "commencement exercises" attended by some 250, instructors and students, on the closing day. After the delicious luncheon, Dr. Ward, as chairman, opened the "graduation program." Dr. Leone was in charge of the community singing. Expressions of thanks were made to the various groups through whose activity the institute was made possible, the students' representatives for these talks being Miss Brown of Muncie, Mr. Alexander and Miss Morrison. A poem for the occasion composed by Miss Doe was read. A high spot of the program was the "valedictory" of Thomas A. Hyde, Jr., who, arrayed in cap and gown, and with all the gestures and inflections of a valedictorian at the zero hour delivered himself of numerous humorous digs and comments relating to happenings among the student body.

"The committee on mental relations," read part of the valedictory, "deplores the fact that the seminars were so involved. They claim the situation evolving from the giving of names from the floor made for fatal confusion. I cite the pitiful case when a fellow student rushed up to me, shook my hand and said hoarsely, 'I know you now! You are Dinsmore Caldwell of Chicago Harlem Hospital, New Orleans, California.' "

"When we came we were innocent children," said another part of Mr. Hyde's paper, "secure in the opinion that around us lay opportunities for better situations. We have since learned that our neighbor's job is, if anything, just a little less desirable than our own. We came here with the rather infantile conception of the hospital as a place for the sick. Now we know it to be a hotel with

double rooms, drug store, filling station. There are also some little details such as a bonded indebtedness and an occasional leaky roof."

Dean Spencer of the school of business, Robert Jolly, president-elect, American Hospital Association, Mr. Fesler, Dr. MacEachern and Dr. Davis spoke briefly. The entire affair was conducted in the most informal and friendly manner, but it was evident that the expressions of gratitude were genuine, as were the tributes paid to the class by the lecturers, especially those from the university.

The luncheon concluded with the presentation to Miss Ruth Brannan, secretary of the institute, of well chosen gifts from the students, Dr. Leone making the presentation. Following this, the students were given their certificates of attendance. One hundred and thirty-eight students qualified for these, the requirements being 80 per cent attendance at lectures and 75 per cent attendance at clinics.

The Chicago Hospital Association, Paul H. Fesler, superintendent, Wesley Hospital, president, provided several social events that seemed to be much enjoyed and cordially welcomed. The association was host to the students at a banquet on the opening night of the Institute, and took advantage of one Saturday holiday from lectures to take more than 100 of the visitors through the huge plant of John Sexton & Company and to the studios of the National Broadcasting Company. John Sexton & Company was host for this most enjoyable affair, providing buses for the pleasant trip from the university campus and also serving a delicious luncheon. Practically all of the visitors were amazed at the size of this well known institutional food products firm, and noted with interest the coffee, olives and similar items which are imported directly in huge quantities. Besides going through a number of departments and having various steps in processing and manufacture explained and demonstrated to them, the visitors also were given an opportunity to see something that the majority of Chicagoans do not even know to be in existence, the freight tunnel system which operates 90 feet below the surface of the Loop and serves every large building in the Loop. The Sexton plant has a station on this system, and the entire party went down into the tunnel and explored it.

Another trip provided for the students under the auspices of the American Hospital Association was to the Mercy Hospital X-ray department where there is the world's most powerful installation, equipment developing 800,000 volts. The General Electric X-ray Company provided transportation for this.

It is announced that copies of the transactions of the institute in mimeograph form are available to all interested at $7.50 per copy. These transactions were offered to the students first and the response has been so satisfactory that it was felt that many unable to attend the institute would like copies. Those interested should write to John C. Dinsmore, University Clinics, Chicago, Ill.

"Class of 1933, A. H. A. Institute"

Lucy B. Abbott, superintendent, Wm. W. Backus Hospital, Norwich, Conn.

Albert E. Abernathy, superintendent, Lake View Hospital, Chicago.

*Florinda O. Abrahamson, Chicago.

T. F. Alexander, superintendent, Tampa., Fla., Municipal Hospital.

*V. Ray Alexander, executive secretary, Missouri Hospital Association, St. Louis.

*Jessie P. Allan, superintendent, Kingston, N. Y., Hospital.

*William R. Allen, assistant superintendent, Flower Hospital, Toledo, O.

*Sister Mary Aloise, R. N., superintendent of nurses, Sacred Heart Hospital, Le Mars, Ia.

*Norma A. Anderson, night supervisor, W. C. A. Hospital, Jamestown, N. Y.

Ruby F. Anderson, R. N., superintendent, Volga Hospital, Volga, S. D.

*Adeline Aschliman, assistant superintendent, S. M. Heller Memorial Hospital, Napoleon, O.

*Eva Atwood, superintendent, St. John's Hospital, Ft. Smith, Ark.

*Sister Mary Avellino, R. N., A. B., superintendent, Mercy Hospital, Scranton, Pa.

Gertrude Baker, R. N., superintendent, Willard, O., Municipal Hospital.

*Isabell Grace Bambridge, operating room supervisor, Saskatoon, Sask., City Hospital.

*Mabel Barr, administrator, St. Christopher's Hospital for Children, Philadelphia.

Francis J. Bath, business manager, Creighton Memorial St. Joseph's Hospital, Omaha, Neb.

*Hazel M. Bennett, assistant superintendent, Shaw Clinic and Hospital, Marlin, Tex.

*Richard Baker Benson, statistician, Methodist Episcopal Hospital, Indianapolis.

*Sister Mary Bertrand, R. N., floor supervisor, St. Catherine's Hospital, McCook, Neb.

Walter G. Beyer, office manager, Garfield Park Community Hospital, Chicago.

*Rear Admiral N. J. Blackwood, M. D., U. S. N. (Ret.), medical director, Provident Hospital, Chicago.

*Helen Mildred Blaisdell, R. N., superintendent, Westerly, R. I., Hospital.

*Josephine Blalock, office manager, Chicago Memorial Hospital.

Otto I. Bloom, B. S., M. D., acting superintendent, Peoples Hospital, New York.

George F. Brewster, M. D., manager, U. S. Veterans' Hospital, Northport, N. Y.

*Nellie Gates Brown, superintendent, Ball Memorial Hospital, Muncie, Ind.

*Dr. W. H. Bruce, superintendent, Wheatley Provident Hospital, Kansas City, Mo.

Mrs. Josephine Brunk, superintendent, Kansas City Tuberculosis Hospital, Kansas City, Mo.

*Elmer S. Bulkley, pharmacist and assistant superintendent, Tompkins County Memorial Hospital, Ithaca, N. Y.

*Wesley R. Burch, in charge nights, Michael Reese Hospital, Chicago.

*N. Josephine Cass, superintendent, W. B. Plunkett Memorial Hospital, Adams, Mass.

*A. J. Chopin, executive secretary, St. Mary's Hospital, Montreal, Que.

*James Vernon Class, auditor, University Hospitals, Cleveland.

*Iola Claypool, supervisor, Methodist Hospital, Peoria, Ill.

Frederic D. Coffey, comptroller, Provident Hospital, Chicago.

*Clara A. Coleman, superintendent of nurses, City Hospital, St. Louis, Mo.

*Mrs. Z. V. Conyers, superintendent, Sternberger Children's Hospital, Greensboro, N. C.

Gladys A. Cooper, bookkeeper, American Oncologic Hospital, Philadelphia, Pa.

*Hugh A. Cooper, superintendent, Southwestern Presbyterian Hospital, Albuquerque, N. M.

*Hugh P. Cooper, business manager, Southwestern Presbyterian Hospital, Albuquerque, N. M.

*E. Ray Cosgrove, business manager, Mount Mercy Sanitarium, Hammond, Ind.

*Bessie Cottrell, superintendent, Cameron Hospital, Angola, Ind.

*Grace Crafts, superintendent, Madison, Wis., General Hospital.

*Louise Creamon, R. N., superintendent of nurses, Burrell Memorial Hospital, Roanoke, Va.

Katherine M. Crozier, superintendent, Heaton Hospital, Montpelier, Vt.

Eunice Cole, assistant superintendent, Heaton Hospital, Montpelier, Vt.

*Sister Mary Cyril, R. N., superintendent, Sacred Heart Hospital, Le Mars, Ia.

*Charles Henry Dabbs, superintendent, Tuomey Hospital, Sumter, S. C.

*Charles D. Davol, business manager, Truesdale Hospital, Fall River, Mass.

*Maud Folsom Denico, superintendent, South County Hospital, Wakefield, R. I.

Mrs. Alma M. Denne, superintendent, Roseland Community Hospital, Roseland, Ill.

*Albert W. Dent, superintendent, Flint Goodridge Hospital, New Orleans.

*Rose Catherine Devine, superintendent, Wabash County Hospital, Wabash, Ind.

Some of the 800 uniformed nurses and of the thousands who heard them sing at Hospital Day at A Century of Progress, which served as a prelude to the opening of the American Hospital Association Institute at the University of Chicago. The chorus overflowed the stage of the Court of the Hall of Science.

*Sister Mary Reginald, R. N., R. S. M., superintendent, Mount Mercy Sanitarium, Hammond, Ind.

*Florence M. Doe, R. N., Toronto.

*James Murray Dunlop, credit clerk, Montreal General Hospital, Montreal, Que.

Halbert L. Dunn, M. D., director, University Hospitals, Minneapolis.

*Dr. George W. Duvall, Central Free Dispensary, Chicago.

Lucille M. Engel, superintendent, Western Minnesota Hospital, Graceville.

*Sister Mary Fabian, O. P., superintendent, St. Catherine of Siena Hospital, McCook, Neb.

*Carolyn M. Fenby, superintendent, Methodist Hospital, Madison, Wis.

*Leon Elias Fineman, second senior assistant alienist, New York City Children's Hospital, Randall's Island, N. Y.

*Mary Jeanette Fraser, R. N., superintendent, General Hospital, Port Arthur, Ont.

*Gordon Arthur Friesen, accountant, Saskatoon, Sask., City Hospital.

*Roland G. Fritschel, assistant to superintendent, Milwaukee Hospital, Milwaukee, Wis.

*Lee Clyde Gammill, superintendent, Baptist State Hospital, Little Rock, Ark.

Edythe L. Gappinger, R. N., superintendent of nurses, Garfield Park Community Hospital, Chicago.

*Mrs. Mabel K. Graham, R. N., superintendent, Rowan General Hospital, Salisbury, N. C.

*F. Graves, R. N., superintendent, Methodist Hospital, Peoria, Ill.

C. H. Grimm, business manager, Springfield Lake Sanatorium, East Akron, O.

*Goldie Kent Gruver, superintendent of nurses, Uniontown, Pa., Hospital.

Amy S. Gundersen, R. N., superintendent, Swift County Hospital, Benson, Minn.

*Eva Hagan, clinic director and S. S. director, Women and Children's Hospital, Chicago.

*Jean M. Hall, superintendent, Locust Mt. State Hospital, Shenandoah, Pa.

*Sister Theodosia Harms, R. N., superintendent of nurses, Bethel Deaconess Hospital, Newton, Kan.

*Mrs. Mary Allen Hart, supervisor, Florida Medical Center, Venice, Fla.

*Iva Louise Hartman, superintendent, Pinehurst Sanatorium, Janesville, Wis.

Charles J. Hassenauer, superintendent, Garfield Park Community Hospital, Chicago.

*H. Robert Haupt, business manager, Macon County Tuberculosis Sanatorium, Decatur, Ill.

*Caroline Herrl, R.N., superintendent, Waukesha, Wis., Municipal Hospital.

*Mae Hindman, superintendent, Palo Alto, Calif., Hospital.

*Delphine Hines, R.N., superintendent of nurses, Ancker Hospital, St. Paul, Minn.

*Astrid Hofseth, R.N., Evanston, Ill.

*Minnie Amanda Hokanson, superintendent, Woman's Christian Association Hospital, Jamestown, N. Y.

*N. O. Hoover, superintendent, Mennonite Hospital, Bloomington, Ill.

*Mrs. Bess Claypool Hornbeak, Springfield, Mo.

*Raymond F. Hosford, superintendent, Bradford, Pa., Hospital.

*Francis Clark Houghton, assistant steward, Butler Hospital, Providence, R. I.

James Howarth, assistant business manager, Glendale, Calif., Sanitarium and Hospital.

Mrs. J. P. Hughes, superintendent, American Oncologic Hospital, Philadelphia, Pa.

*Thomas A. Hyde, Jr., purchasing agent, Christ Hospital, Jersey City, N. J.

Marjorie M. Ibsen, superintendent, Highland Park, Ill., Hospital.

*E. Atwood Jacobs, assistant director, St. Lukes and Children's Hospital, Philadelphia.

*Mary A. Jamieson, Columbus, O.

*Neil Livingston Jamieson, Jr., Columbus, O.

J. Howard Jenkins, superintendent, Thomas D. Dee Memorial Hospital, Ogden, Utah.

*James Harvey Jennett, M.D., superintendent, Kansas City, Mo., General Hospital.

Clara Regina Johnson, night superintendent, Samuel Merritt Hospital, Oakland, Calif.

*Margaret Johnston, R.N., superintendent, Beloit, Wis., Municipal Hospital.

*Mrs. Edna Jones, superintendent, Madison, S. D., Community Hospital.

*Franklin Jones, assistant manager, Medical and Surgical Hospital, San Antonio, Texas.

*Mrs. Florence P. Katz, business manager, Clark County Memorial Hospital, Jeffersonville, Ind.

*Mrs. Elizabeth Kingsford, superintendent, Wheeler Hospital, Gilroy, Calif.

*Macie N. Knapp, superintendent, Brokaw Hospital, Normal, Ill.

*Anna Koenig, R.N., assistant director, Mount Sinai Hospital, Chicago,

*Indicates those receiving certificates for completion of course.

Ethel B. Kyle, R.N., superintendent, Kewanee, Ill., Public Hospital.

*Henry Veere Lacy, superintendent, Foochow Christian Union College Hospital, Fochow, China.

*Joseph P. Leone, M.D., assistant superintendent, Rhode Island Hospital, Providence, R. I.

*H. Chester Larrabee, assistant superintendent, Binghamton, N. Y., City Hospital.

*Charlotte F. Landt, R.N., superintendent, Memorial Hospital, Casper, Wyo.

Rose L. Laughton, superintendent, Children's Hospital, Moose Jaw, Sask.

*Genevieve N. Lechevet, R.N., superintendent, Aurelia Osborne Fox Memorial Hospital, Oneonta, N. Y.

*Mildred S. Lunde, superintendent of nurses, Riverside Hospital, New York City, N. Y.

*Geo. Macatee, assistant to superintendent, Garfield Memorial Hospital, Washington, D. C.

*Edith Martin, superintendent, Stouder Memorial Hospital, Troy, O.

*Lula F. Martin, business manager, Methodist Hospital, Princeton, Ind.

*Mary Martin, R.N., superintendent, City Hospital, Newark, O.

I. W. J. McClain, superintendent, St. Luke's Hospital, Utica, N. Y.

*Catherine Mae McDermott, educational director, Employees Hospital, Fairfield, Ala.

Helen McInnes, superintendent of nurses, Rockford, Ill., Hospital.

Helen B. McLeod, co-superintendent, Camden, Ark., Hospital.

*Mrs. Lina McMahon, superintendent, Nan Travis Memorial Hospital, Jacksonville, Texas.

Elizabeth C. McMillian, superintendent, Hillsboro County Tuberculosis Sanatorium, Tampa, Fla.

*Norma Evlyne McNair, supervisor, obstetrical ward, City Hospital, Saskatoon, Sask.

*Mary G. McPherson, R.N., superintendent, Ellis Hospital, Schenectady, N. Y.

*Dr. Louis Mendez, director, General Hospital, Mexico City, Mexico

Mrs. Ruth Lois Moloney, R.N., superintendent, Memorial Hospital, Norwalk, O.

*Pearl L. Morrison, R.N., superintendent of nurses, Sibley Memorial Hospital, Washington, D. C.

Katharine A. Moyer, superintendent, Lake Wales, Fla., Hospital.

*Salvador M. Navarro, Mexico City, Mexico.

*Sarah S. L. Nicholl, superintendent, Exeter Hospital, Exeter, N. H.

*Rachel Nickerson, assistant superintendent, Sylacauga, Ala., Infirmary.

*Helen Thom Nivison, R.N., superintendent, Griffin Hospital, Derby, Conn.

Belva L. Overton, R.N., superintendent of nurses, Provident Hospital, Chicago.

Mrs. Catherine E. Owens, superintendent, Bellevue, O., Memorial Hospital.

*Beulah L. Patteson, R.N., superintendent, Samaritan Hospital, Nampa, Idaho.

Grace Phelps, superintendent, Doernbrecher Hospital, Portland, Ore.

Ellen Phillips, superintendent, St. Mary's Hospital, Russellville, Ark.

*Sophia Potgieter, superintendent, Country Home for Convalescent Children, West Chicago, Ill.

*Margaret Pringle, R.N., director of nursing education, St. Luke's Hospital, Marquette, Mich.

Here is the registration at the 1933 institute of hospital administration, sponsored by the American Hospital Association and allied groups and conducted at the University of Chicago. The list is as given out by Ruth Brannan, secretary to John C. Dinsmore of University Clinics. Miss Brannan impressed everybody with her ability, her endless good humor and her ever-present willingness to help students solve problems connected with institute attendance, etc. In addition she was a walking encyclopedia of information about how to get to the different hospitals for the clinics and of facts about almost any subject that was broached to her.

Kate M. Putnam, superintendent, McKinley Hospital, Urbana, Ill.

*Ethel M. Reesor, superintendent, Chas. S. Gray Deaconess Hospital, Ironton, O.

Sister Anna Regina, superintendent, St. Joseph's Hospital, Pittsburgh, Pa.

*Norman Jeffery Rimes, superintendent, Christ's Hospital, Topeka, Kans.

Sister M. Rodriguez, O.S.F., R.N., superintendent, Georgetown University Hospital, Washington, D. C.

Harold Lambert Scammell, medical assistant superintendent, Victoria General Hospital, Halifax, Nova Scotia.

*Elizabeth T. Schmidle, superintendent, Miami-Inspiration Hospital, Miami, Arizona.

*Emma M. Schumacher, R.N., superintendent, S. M. Heller Memorial Hospital, Napoleon, Ohio.

Alverna See, R.N., superintendent, Burnham City Hospital, Champaign, Ill.

*Ruth J. Sewers, statistician, Cincinnati General Hospital, Cincinnati, Ohio.

*N. Gertrude Sharpe, superintendent, Morton Hospital, Taunton, Mass.

*Carlos E. Shepard, business manager, Pine Crest Sanatorium, Oshtemo, Mich.

*Flora G. Smith, R.N., maternity supervisor, Methodist Hospital, Indianapolis.

Sister Lena Mae Smith, R.N., principal of training school, Bethel Deaconess Hospital, Newton, Kansas.

Nellie C. Smith, R.N., superintendent, Ohio Valley Hospital, Steubenville, O.

*Caroline T. Snyder, superintendent, Trinity Hospital, Little Rock, Ark.

Ernest R. Snyder, assistant superintendent, Wesley Memorial Hospital, Chicago.

*Ruth V. Sourwine, auditor and office manager, Flower Hospital, Toledo, Ohio.

Martha R. Speer, R.N., superintendent, Columbia Hospital, Wilkinsburg, Pa.

*Samuel Steinholtz, M.D., deputy medical superintendent, Harlem Hospital, New York.

*Katherine B. Stott, R.N., superintendent of nurses, Ingalls Memorial Hospital, Harvey, Ill.

*Lillian A. Sutton, superintendent, Amesbury, Mass., Hospital.

*Clara E. Swanson, superintendent, R. F. Strickland and Son Memorial Hospital, Griffin, Ga.

*Louis M. Teffeau, superintendent, Michigan Masonic Home and Hospital, Alma, Mich.

*Stella B. Teffeau, R.N., Michigan Masonic Home and Hospital, Alma, Mich.

*Sister Mary Theodore, R.N., supervisor of surgery and X-ray, Mercy Hospital, Scranton, Pa.

*Esther J. Tinsley, R.N., superintendent, Pittston, Pa., Hospital.

Charles E. Vadakin, accountant, Marietta, O., Memorial Hospital.

*Herman H. Van Horn, M.D., pathologist, Polyclinic Hospital, Harrisburg, Pa.

*Edwin St. John Ward, M.D., superintendent, Hospital Cottages for Children, Baldwinville, Mass.

*Mrs. Olive V. Wardrop, superintendent, St. Mark's Hospital, Salt Lake City, Utah.

*George Theodore Weber, II, assistant business manager, Olney Sanitarium, Olney, Ill.

*Dr. Sophie Wellisch, superintendent, Miriam Convalescent Home, Webster Groves, Mo.

*Frances P. West, superintendent, Middlesex Hospital, Middleton, Conn.

*Clara W. Widdfield, Toronto, Ont.

*Floyd Whipple, Guthrie, Okla.

*Esther Wilson, R.N., superintendent, Salem, O., City Hospital.

*Ruth C. Wilson, business manager, Moncton Hospital, Moncton, N. B.

Robert B. Witham, director, Children's Hospital Denver, Colo.

*Jessie M. Woodfin, head nurse, Drummond Fraser Hospital, Sylacauga, Ala.

*Major H. Worthington, M.D., managing officer, Illinois Research and Educational Hospital, Chicago.

*Carl P. Wright, Jr., executive assistant to director, Grasslands Hospital, Valhalla, N. Y.

*Almena E. Wuerthener, superintendent, Presbyterian Hospital, San Juan, Puerto Rico.

Mrs. Mary A. Young, superintendent of nurses, Moose Jaw, Sask., General Hospital.

15 Years Ago—THIS MONTH—10 Years Ago

From "Hospital Management," October 15, 1918

A. H. A. convention at Atlantic City gives much attention to demands on hospitals due to war conditions. Dr. Warner named president and Cincinnati chosen as 1919 convention city.

American College of Surgeons announces that "First Hospital Survey of the College" would be reported on at the second annual hospital conference in New York.

Hospital employes placed in deferred draft classifications.

Editorial comments on fact that A. H. A. 1918 convention reported that numerous rate increases had been necessary among hospitals.

From "Hospital Management," October 15, 1923

President Bacon outlines plans for "silver jubilee" convention of A. H. A. at Milwaukee.

National Hospital Day Committee invited to have exhibit at A. H. A. meeting.

E. I. Erickson succeeds the late Dr. Wahlstrom as superintendent of Augustana Hospital, Chicago.

Description of a "Bacon plan" hospital published for first time.

Deaconess Hospital, Wenatchee, Wash., reports successful use of hospital membership plan (somewhat similar to group hospitalization).

Butterworth Hospital, Grand Rapids, Mich., revises hospital rules after consideration of regulations of numerous other institutions.

How to Borrow Money from U. S. For Hospital Construction

ACCORDING to reports from different parts of the country, numerous hospitals are endeavoring to take advantage of Title II, Public Works, of the National Industrial Recovery Act, which authorizes the loan by the government to hospitals supported in part by public funds of sums for construction purposes.

Hospitals are specifically mentioned in the Act as being eligible and those desiring detailed information concerning the method of applying for a loan and the conditions to be met should carefully study circular No. 1 of the Federal Emergency Administration of Public Works, Washington, which is obtainable from the government printing office or, probably, from the State Public Works Administration in each state.

It is important to know that application for a loan must be made to the State Public Works Administration and that the state body is the source of all information concerning details of the loan, method of application, conditions of construction, and so on.

Frequently in the circular of information issued by the Federal Emergency Administration of Public Works, reference is made to the fact that the state advisory board in each state is the source from which all information must be sought and the body which will make the decision in a given instance.

From circular No. 1, which explains the purpose, policy, function and organization of the Emergency Administration, based on the rules prescribed by the President, the following is summarized:

Under article 1, which lists non-federal projects eligible for loans, it is stated that such projects shall be held "to include loans for the construction or completion of hospitals, the operation of which is partly financed from public funds." A note adds, "such hospitals are thus within the classes eligible for loans."

The circular also describes in detail, policies of the Emergency Administration of Public Works, with reference to labor, wages, eligible contractors, provisions of the contract, etc. In regard to labor, the conditions require that no convict labor be employed, that as far as practicable no individual shall work more than thirty hours in one week, except those in executive, administrative or supervisory positions, that all employes be paid just and reasonable wages, that preference be given, where they are qualified, to ex-service men with dependents.

Another note says that it is intended that a schedule of wages be furnished by the state advisory board and the state engineer of the Public Works Administration to determine minimum wages. The contractor is required to post in a prominent place at the site of the work a statement of all wage rates paid.

Another part of the circular referring to the immediate program of the administration mentions "projects that can be started within thirty days and which are necessary and convenient from a social standpoint."

In regard to loans, the following is excerpted from Part 2 of the Circular:

All loans to private corporations must be well secured. If the prudently estimated revenues of the project are more than ample to liquidate the loan, then this margin of safety over and above the minimum requirements will in itself offer some measure of security, but in general the applicant will be required to offer as security collateral or a mortgage on property worth, as appraised by the administrator, at least 50 per cent in excess of the amount of the loan. The administrator will not lend money to reimburse previously incurred expenditures, nor to purchase existing facilities, unless such items of cost are clearly necessary to create or accomplish the project. Consideration will be given to applications involving such expenditures provided they aggregate less than 15 per cent of the total loan. No loans will be made to private corporations for a period of more than 10 years from the date of the loan; but if the prudently estimated revenues of the project will liquidate at least 50 per cent of the loan in this period, thus indicating the ability of the project to obtain refinancing in a normal money market, the administrator will accept an obligation to repay the remainder of the loan, not exceeding 50 per cent, at the end of the tenth year. Loans will not be made to private corporations where the project can be shown to compete injuriously with existing and adequate facilities.

The circular emphasizes the proper routine in applying for a loan in the following words:

"Applicants should address their applications to appropriate state advisory boards and in four counterparts."

The necessity of having four copies of the application is mentioned several times in the circular, also the fact that the application should be made to the state advisory board in the state in which the proposed project is located.

Organization of Record Department, Packer Hospital, Sayre, Pa.

By ALICE WHITE

Record Librarian, Robert Packer Hospital, Sayre, Pa.

THE executive departments of the Robert Packer Hospital are located in the Guthrie Clinic Building which is connected with the hospital. The record room, just off the main lobby on the ground floor is in charge of a record librarian and one assistant. The work there is confined to the registration of patients, the filing of records, and the keeping of statistics. All details in connection with the admission of patients are handled by the admission department. All hospital histories are written by the interns and fellows in surgery and medicine. The histories are read by the staff members and if satisfactory are signed by them. The alphabetical file of registration cards comprises both clinic and hospital patients. The Soundex system of filing is used. Each new patient coming to the clinic or hospital is first registered. Since the unit system of numbering patients is used (each patient having only one number no matter how many times he may come for treatment), great care has to be exercised that patients are not re-registered. Before a registration can be made the name is always looked for in the alphabetical file. A cross-file of married women's first names is made. Each registration card contains: name in full with last name first; address; age; legal status; name and occupation of person responsible for the bill.

Clinic patients are directed to the proper departments for examination by the registration secretary except in case of emergencies when they are admitted directly to the hospital ward or room. The unit system requires that emergency cases be registered in the usual manner. Following registration a history sheet is sent to the proper floor or room. This history sheet is headed with the same information that is on the registration card and with the referring doctor's name and address. To this record is attached an envelope to be used for financial information. A clinic account card is sent to the business office. If a patient is later admitted to the hospital, all these records are attached to the hospital chart. In an accompanying view of the interior of the record room are shown hospital chart holders displaying the back pocket where previous records of the patient are kept while the patient is in the hospital. Each time that a patient returns to the clinic or to the hospital all previous records are taken from the record room for the use of the doctors. Since the unit system has been in use only six years, records filed under the old system of numbering have to be attached to the current records. The new number is written on any old records. All records used in the clinic are returned to the record room each night.

In order to systematize the keeping of statistics for use in making out hospital, state and miscellaneous reports, daily lists of patients in each department of the clinic are turned in to the record room. There in the table file shown at the extreme left of the interior view of the record room is kept a numerical file of all patients, which is a duplicate of the alphabetical file. On the backs of the cards in the numerical file are checked the dates of each clinic visit of each patient. At the same time the names on the lists of clinic visits are classified as "new," "old," "visit new," or "visit old." "New" is a first visit made. "Old" is a first return visit after a lapse of three months. "Visit new" is any return visit of a patient registered within three months. "Visit old" is any return visit of a patient registered more than three months ago. The number of each kind of patient according to this classification is later entered for each day in tabular form. A count of the total patients in each department of the clinic is kept for the use of the cost accountant.

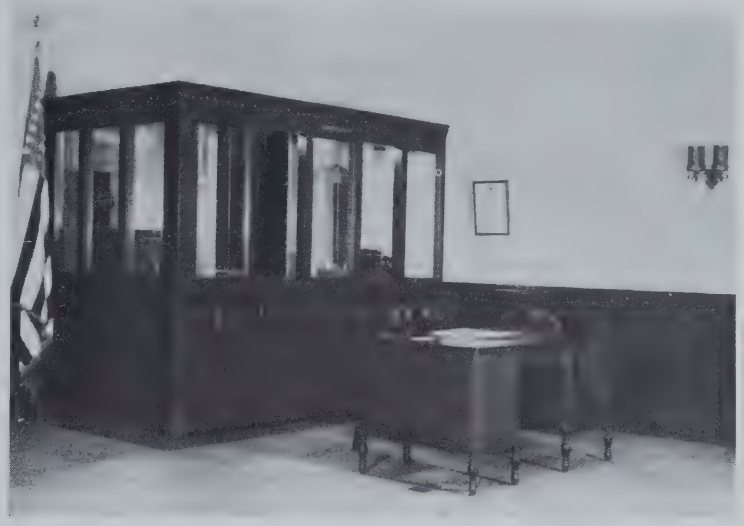
Daily 24-hour reports of admissions to the hospital are sent to the record room. There the date of admission is entered on the front of each patient's card in the numerical file. Tabulations are kept on the daily totals of males and females, males and females under thirteen years of age, and male and female new borns.

The charts of discharged patients are sent to the record room. There the diagnosis on discharge and the result of treatment are copied onto the admission card and the card is detached. Then the chart is condensed and filed. Each admission

Note hospital chart holders with back pocket for previous records of patients. At extreme left is the numerical list of patients.

history is bound separately and then clipped with any other records of the patient. From the admission cards of discharged patients the number of patients discharged daily is tabulated under four separate classifications. One tabulation includes the number of male and females (1) cured, (2) improved, (3) unimproved, (4) died, (5) died within 48 hours. A second tabulation includes the number of male and female adults and the number of male and female children under thirteen years of age: (1) surgical, (2) traumatic, (3) orthopedic, (4) eye, ear, nose and throat, (5) dental, (6) obstetrical, (7) neurological, (8) infectious, (9) contagious, (10) pediatric, (11) medical, (12) gynecological, (13) new born, (14) urological, and (15) dermatological. Separate tabulations of church affiliations and addresses are kept.

The record room also comprises a clinical index and an operation index arranged in accord with the Mercur nomenclature. The first is posted from the diagnoses on the admission cards of discharged patients. The second is posted from small operative cards sent from the operation room of the hospital. Thus, in addition to providing for the current needs of a modern hospital of 250 beds and a clinic treating an average of 80 patients a day, the record room is able to give prompt service to the doctors needing case records and statistics for use in preparing clinical papers for staff meetings, articles for professional publications, and talks for medical meetings.



"The work (of the record department) is confined to the registration of patients, filing of records and keeping of statistics."

Offers Family Group Hospitalization

By BRYCE TWITTY

Superintendent, Baylor University Hospital, Dallas, Tex.

BAYLOR University Hospital now is using a Family Plan of group hospitalization. This plan applies only to the family of the groups of employed people whom we are already covering.

Before initiating this plan we used all the information available through our own experience of better than 10,000 active members and all other available sources. Such plans were in operation through mining camps, lumber camps, oil towns, etc. We found several things, both by experience and experience of others, to be true without exception with the family:

First, that any group of women will use from three-fourths to twice as much hospital service as the same number of men.

Second, that housewives will use one-third more than employed women and that children will come to the hospital many times when otherwise they would stay at home where the plan is in service.

So, the only safe plan that we could see was to penalize in some way or put a premium in some form for the housewives and children. We give them all of the benefits of the plan as in force by the employed groups except they pay 50 per cent of the room charge. This takes care of all the uncertainty of the operating room, anesthetic, laboratory, etc.

When they come to the hospital they know exactly what their expense will be. For instance, if a housewife comes in on the plan for a major operation and selects a $5 per day private room she will get everything on the plan by paying $2.50 per day. She will pay us $2.50 per day in addition to the monthly premium, which they have been paying. While it is not much it will prevent her from coming to the hospital when it is not necessary.

A circular describing the plan says:

"Baylor University Hospital now offers to the members of its group hospitalization plan a family plan for their wives and minor dependent children. For membership in this plan members of the hospitalization groups will pay an additional rate of $1 per month per family, with an initial registration fee of $1 per family. Family membership in this plan assures the wife and minor dependent children the following services and discounts:

1. All needed operating room service.
2. All necessary anesthesias and anesthetic service.
3. All needed pathological laboratory service of every kind, as indicated, and ordered by your doctor during hospitalization, including blood count, blood chemistry, urinalysis, blood typing, gross and microscopic examination of all surgical sections, etc., etc.—in brief, the entire services of a pathological laboratory devoted entirely to hospital service.
4. All medicines.
5. Surgical dressings.
6. Hypodermics.
7. First aid and emergency treatment, at direction of the physician.
8. Surgical binders.
9. Casts and operating room supplies.
10. General nursing care, including graduate head nurses and supervisors.
11. The services, at the disposal of the patient's physician, of the house staff of Baylor University Hospital, including a medical director, a resident house physician, a resident house surgeon, a resident obstetrician, and eleven other graduate physicians ready at any hour to render first aid or relief assistance.
12. All of the services of the general employes and professional staff of Baylor University Hospital.
13. Fifty per cent off for treatment indicating aseptic maggots or aseptic anopheles mosquitoes.
14. Fifty per cent off from electrocardiogram tracings in heart cases.

(*Continued on page* 46)

Saving Without Sacrificing Service

By CARROLL H. LEWIS

Executive Director, The Christ Hospital, Cincinnati, O.

MOST of those of us in charge of hospitals bristle with indignation when anyone suggests that we reduce expense and operate more cheaply. Usually we remind the board member or whoever else may have had the temerity to make such a suggestion that in order to maintain our high standard of service it is necessary to spend what we were spending or more and then proceed to tell how much more is spent by so and so who runs another hospital in town than by us. This is a natural and so understandable reaction. But these last two years greater economies than ever have been forced on us, not by suggestion, but by the situation so well known to all of us. Our own efforts have availed much and the record of the hospital industry has been one much envied by the banker, once proud lord of all he surveyed and adviser of all and sundry, who couldn't keep his doors open and had to run to his Uncle Sam for aid. The big majority of us have kept open house all year round and are still doing business at the same old stand in better fashion than ever. Let's keep our chins up about that, anyhow.

There are some ways in which we have readjusted our plant actually to save money. Sometimes we try to fool ourselves with a new method of figuring the per capita income and outgo on a new and weird plan that means nothing, but looks good. Let's forget those accounting tricks.

One interesting readjustment has worked in one instance at least. A hospital served the main meal of the day to patients and family at noon. A change was made, and while the patients were still served the main meal at noon, the family had luncheon with heavier meal in the evening. The result was that ten less employes were needed by the simple redistribution of the load and the family worked better for the lighter meal at mid-day.

A hospital eliminated daily chamber-maid service in the nurses' home, requesting students and graduates to make their own beds. Less confusion in linen supply and five fewer employes was the net result.

It was found in a hospital that the design of the student uniforms called for a great deal of hand ironing. This was changed despite some alumnae rumblings and four employes in the laundry were eliminated.

"Hospital Management" publishes this paper as it was given at the 1933 Protestant Hospital Association in line with its policy of opening its columns to both sides of a controversial question of general interest. It cordially invites those who differ with any views expressed in this paper or any other it publishes to comment at any time.

A hospital head discovered one day that 18 employes had arranged with doctor friends to be furnished with prescriptions for reducing diets. The diet department explained that an extra person was needed to take care of the over-stuffed sisters. A deduction of five dollars a month from the salary checks adjusted this difficulty almost at once. For a short time extra income for the diet department was provided, but soon the dieters here so reduced financially and otherwise that the diet department was spared an increase in personnel.

A budget may be balanced other than by reduction of expense. Increase of income is much more pleasing. This may be accomplished by charging employes a reasonable amount for services rendered them by the institution. This also increases their appreciation of the value of the services of the hospital and this in itself is a valuable asset.

These and a thousand other experiments have been tried during the past years. Each institution knows its own problems and the individual aims and ends desirable of attainment and the adjustments that can be arranged. There are some general changes which could well be made to the mutual advancement of all hospitals toward the end of more income, less expense and constantly improved service.

For example, I feel that we would all be much wiser to do far less advertising of our so-called free service. There is no such thing as free service—somebody has to pay for it. When pay patients see their bills they think that they are paying for the poor man's care. To have people hold this idea is a costly thing for hospitals. If we are going to do charity, it is at least unscriptural for us to advertise it. Also it is bad business. We give to the uninformed layman just enough information about our costs to prove beyond shadow of doubt that a little knowledge along these lines is a dangerous thing for hospitals. Also, we have no right to compel our guests to contribute to our pet charity. That is poor hospitality and much poorer business. If we must take care of our sick poor out of compulsory collections from our pay patients let's keep it dark and hope that what people don't know won't hurt us.

Another thing! We may reduce expense and maintain service by compelling certain groups who would operate hospitals solely for their own professional ends to keep their hands off of our property. For example, nursing groups.

There were no nurses until hospitals called them into being. The desire of the hospital to improve the technical knowledge of those who cared for the sick under its roof was the beginning of nursing in general. Now in many places the nursing profession is trying to reverse the natural order of this thing and arrange the whole situation to suit the nursing profession. The profession is highly organized and some of its leaders exist only out of the earnings of the group. Their contribution is highly questionable in value to either their supporters or the hospitals. Their demands in many cases are unreasonable and their recent cry about an overcrowded profession has been raised largely to secure their own jobs against the growing competition of larger numbers. The very hue and cry that they have raised has advertised nursing as a desirable profession far beyond the advertising given by hospitals. Their chief attempt at regulation has been to limit the intake. There are a lot of nurses, but still too few good ones.

When the hospital administration sits quietly by and allows this group or any other group to exploit the sick people under their roofs for personal gain we are proving false to our trust. I am for the highest possible standards in nurse training; I am for a fair distribution of the opportunities for employment, but when the time comes that there are

enough jobs for all nurses whether they deserve them or not, the hospitals will become sorry affairs dominated by a protected mediocrity that will destroy itself and necessitate the rebuilding of the whole hospital program.

How determined are some nursing groups to gain control of our hospitals? Within the last six weeks all Ohio hospitals were notified by the State Medical Board that no school of nursing however excellent would be accredited by that state unless the head nurse in charge of that school was allowed to attend the regular meeting of the board of directors and present her report in person. Why? Because, to quote the order, no "honest" picture of nursing could be presented to the board in any other way. Our head nurses are trying to crash the gate into places to which they have not been invited. The state hospital association knew nothing of this order until the superintendents received it. This is the power and determination of the nursing group to disregard the hospital head and go directly to the governing board. Evidently the efforts of the superintendents to keep nursing within the budget has dissatisfied the nursing organization. We should by all right, if nursing attains this hold, permit the dietitian, chief engineer, pharmacist, housekeeper, and each department head to present an honest picture of necessary expenses while the hospital as a whole suffers to its destruction.

Further economy can be obtained by controlling the fads and fancies of the staff when these call for unwise and unwarranted expense. So-called "courtesies" to the staff, meaning free service and overly discounted bills, should be discouraged. This goes for all professional groups, ministers included. The hospital deserves support for its work and service rendered. I have always been glad that the Lord Christ in His best known parable set down to the credit of the Good Samaritan the fact that his crowning act of kindness to the man who fell among thieves was to take him to a hospital and to pay his bill in advance and to tell the hospital superintendent that if there were any more charges they would also be paid when he came again. This is excellent social practice. Our income must be as real as our expenses and fortunately or unfortunately in like kind.

The best way to decrease expense and to maintain high grade service is to place full responsibility for the administration of the affairs of the hospital and the shoulders of the executive head of the hospital, to protect him from the selfish jealousies of any person or group. If the head is not competent, replace him, but until incompetence is proved, back him up and give him the universal human privilege of a few mistakes at least. We are to care for the sick entrusted to us to the best of our ability first and foremost—all else is secondary at most. To stand by this principle is after all the only way honorably to balance the budget.

Saskatchewan's Hospital System

By LEONARD SHAW

General Superintendent, Saskatoon City Hospital, Saskatoon, Sask.

IN Saskatchewan today there are some 64 government-aided hospitals including three sanatoria. There are also 14 Red Cross outposts and a number of private hospitals and nursing homes. The bed capacities of these hospitals range from 10 to 405 beds with a total of 3,957 beds for the province or 1 bed for every 233 people.

During the last two years, the average length of stay in our hospitals, exclusive of the sanatoria, was 13 days per patient. In our Union Hospitals, the average was slightly less than 12 days. In 1931, 6.4 per cent of our population had hospital treatment, and in 1932, 5.7 per cent received treatment, or slightly less than 60,000 people. The average cost per patient per day for all hospitals last year was $2.67 as compared with $2.96 in 1931. The earnings of our hospitals in 1932 were slightly over three million dollars, of which over two millions was accounted for by patients' fees. Operating expenditures were $2,454,610.14, fixed charges amounted to $265,545.78, and capital expenditures to $22,439.98.

Each government-aided hospital receives from the Province 50 cents per day per patient regardless of whether the patient is capable of paying his account or not. This grant is paid to the hospital half-yearly and includes the day of admission and day of discharge. In 1932 this grant amounted to $594,536.00, which is equivalent to $10.76 for each patient admitted.

All aided hospitals are required by law to comply with the Province "Regulations Governing Hospitals" and are under the jurisdiction of the Department of Public Health.

It has been the policy of the government to encourage proposed changes for a period of several years prior to such change becoming compulsory. A typical example is that the 1933 regulations say that no school of nursing should exist in a hospital below a certain bed capacity and unable to fulfill a number of basic requirements and that such legislation comes into force January 1, 1936, thus allowing these hospitals to fulfill their moral contracts with students already in training and prepare a stable form of reorganization.

Our three sanatoria for tuberculous play a very important part in the health of our province, for they represent 715 or 18 per cent of our total hospital beds and in 1932 cared for 2,164 patients.

During 1912 the Anti-Tuberculosis League was created and commenced building a sanatorium at Fort Qu'Appelle in 1914, but due to the war did not open until October, 1917, when accommodation for 80 patients was made available. Patients receiving treatment were required to pay, if able, but when indigent, the city, town, village or rural municipality in which the patient resided was held responsible. During or around 1924, a number of municipalities decided to form a voluntary pool, and by assessment funds were provided to give free treatment in the sanatoria to residents of their municipalities. In 1929 legislation was passed whereby every city, town, village and rural municipality was required to assess its residents to provide free treatment for all tubercular persons.

The Sanatorium at Fort Qu-Appelle, now known as Fort San, has been increased in capacity to 314 beds and two other sanatoria have been built, with every one of their 715 beds being free.

In 1932 the operating cost per pa-

From a paper before 1933 A. H. A. convention.

tient per day, including their medical staff, was $2.55, and it is the opinion of the director of sanatoria, Dr. R. G. Ferguson, that the last two years has seen the high peak of hospitalization of the tubercular, interpreting a highly desirable control of this disease.

The Union Hospital plan perhaps represents the nearest form of socialized hospitalization yet attained in Canada. Due to comparative long distances between our cities, need was apparent for small hospitals capable of handling accidents and maternity work, but the capital expenditure was often too great for any one community to undertake and so between 1917 and 1922 a number of municipalities grouped together to build a hospital at a central point within their group. Such grouping was legalized in 1928, under the Union Hospital Act. A union hospital is one that is built, equipped, maintained and managed by the resident ratepayers of an area consisting of rural municipalities or portions of rural municipalities cooperating with the resident ratepayers of any number of towns or villages in that area. Representatives of any area participating in the plan are on the board of management.

A levy can be made up to two mills on the dollar of assessment for the building and maintenance of the hospital. In these hospitals, free treatment is given to resident ratepayers and families and their immediate dependents. In some areas, the length of hospitalization is limited to prevent hospitalization of the chronic. The local government board of Saskatchewan fixes the share of cost to each municipality. A two-thirds vote is required in a municipality for the adoption of the plan.

Deficits and profits are assessed or returned to the municipalities in the same ratio as their local government board assessment.

The union hospital plan is extremely popular and is serving a great need. Even in these times of financial stress it is doubtful if any area would be willing to relinquish the plan. It is found that there is a very definite form of standardization in the operation of these hospitals which is highly commendable.

The average days' stay per patient is usually one day less in the union hospitals than in other hospitals. This, of course, may be due to the nature of work attempted, but it at any rate indicates that chronicity is not rampant. Free treatment consists of general ward accommodation, operating room fees, drugs, dressings and X-rays. It does not include medical fees, although many municipalities now have their municipal doctor.

All our hospitals have our schedule of charges, based on operating costs, and patients able to do so are required to pay according to these charges, but provision has been made for the payment of all hospital accounts that cannot be born by the individuals.

Saskatchewan is divided into areas or municipalities numbering about 300 divisions. Over and above this, we have our cities, towns and villages, and in the respective acts governing these organized areas is to be found provision for the care of indigent sick, stating that where a person who has been resident in the city, town, village or rural municipality for a period exceeding thirty days who falls ill and is incapable of procuring the necessary medical or hospital aid, that the hospital may admit such patient and charge to the council a sum not exceeding $2.50 per day. If the case is one of emergency, authority for admission from the attending physician is all that is necessary, but when not emergent, authority must be obtained from the council of the area where the patient resides for the admission. The hospital, however, is not required to admit the patient until such authority is obtained.

Reciprocal legislation is now effective between the provinces on either side of us to protect the hospitals near the boundaries. Where a patient has been resident for less than thirty days in the municipality previous to admission to hospital, the hospital board can claim from the municipality in which the patient was last resident for thirty days. There is no provision for transient indigents but it is considered that the government grant will take care of these.

In areas that have not yet been organized as municipalities it is possible to collect through the department of municipal affairs as soon as funds are received into the treasury of the department from these areas.

This method of legalizing the responsibility for practically all hospital accounts has done much to further the standards of hospitalization in our province. It is controlled in such a way that no unfair advantage can be taken by any party and although at the present time our hospitals are being somewhat embarrassed by the inability of the municipalities to pay for all their guaranteed accounts, we feel that the principle is sound, just, and progressive, and we must add that partially to offset this inability the government came further to our aid during the last two years by giving an additional grant of from 25 to 50 cents per patient per day depending upon the area from which the patient came, such areas being classed A, B or C, according to the duration of drouth that they had experienced.

The Saskatchewan Cancer Commission Act was passed in 1930 providing for the establishment of a commission to institute a program of cancer control in the province, embodying three essential factors: education, diagnosis, and treatment. Two clinics are established, one in Regina General Hospital and one in Saskatoon City Hospital, for consultative diagnosis and treatment. A supply of radium was procured and radiotherapy equipment set up.

This commission is affiliated with the British Empire Cancer Campaign. No person has ever been refused treatment because of financial distress, for if they cannot pay, the municipality is made responsible. For those who can pay, a consultation fee of $10 is charged which covers complete diagnostic facilities. If radium is necessary, an extra charge is made, but regardless of the length of the course or amount used, no cost exceeds $50.

We have a real pride in our health programs and particularly our hospitals. While none of them are large, all are built and operated on a sound economic plan which may be borne out by the fact that after nearly four years of depression, only one or two of our hospitals have closed. Because of our youth, we have perhaps benefited by the experience of others. The acid test of health conditions is measured by the death rate and we are proud to be able to report that this is 6.6 per thousand of population, which places us in the envious position of having the lowest death rate of any country issuing official statistics. The maternity mortality rate is 4.4 per thousand living births. Deaths from tuberculosis have reached the remarkable low rate of 36.3 per 100,000 population (this is half the rate for Canada as a whole). Hospital death rates are 3.3 per cent, that is, at the present time, we are about half of the international average.

2,384 Hospitals on 1933 A. C. S. List

Alabama

ANNISTON
Garner Hospital
BESSEMER
Bessemer General Hospital
BIRMINGHAM
Birmingham Baptist Hospital
Children's Hospital
Hillman Hospital
Norwood Hospital
St. Vincent's Hospital
South Highlands Infirmary
DECATUR
Benevolent Society Hospital
DOTHAN
Frasier-Ellis Hospital
Moody Hospital
FAIRFIELD
Employees' Hospital of the Tennessee Coal, Iron and Railroad Company
GADSDEN
Holy Name of Jesus Hospital
JASPER
Walker County Hospital
MOBILE
City Hospital
Mobile Infirmary
Providence Infirmary
United States Marine Hospital
MONTGOMERY
St. Margaret's Hospital
SELMA
Goldsby King Memorial Hospital
Vaughan Memorial Hospital
SYLACAUGA
Drummond Fraser Hospital
Sylacauga Infirmary
TUSCALOOSA
Veterans' Administration Hospital
TUSKEGEE
Veterans' Administration Hospital
TUSKEGEE INSTITUTE
John A. Andrew Memorial Hospital

Arizona

BISBEE
Copper Queen Hospital
FORT DEFIANCE
*Southern Navajo General Hospital
GANADO
Sage Memorial Hospital
JEROME
United Verde Copper Company Hospital
MIAMI
Miami-Inspiration Hospital
PHOENIX
Good Samaritan Hospital
St. Joseph's Hospital
PRESCOTT
Mercy Hospital
TUCSON
St. Mary's Hospital and Sanatorium
Southern Methodist Hospital and Sanatorium
Southern Pacific Sanatorium
Veterans' Administration Hospital
WHIPPLE BARRACKS
Veterans' Administration Hospital

Arkansas

EL DORADO
*Henry C. Rosamond Memorial Hospital
Warner Brown Hospital
FAYETTEVILLE
Fayetteville City Hospital
FORT SMITH
St. Edward's Mercy Hospital
St. John's Hospital
Sparks Memorial Hospital
HOPE
Josephine Hospital
HOT SPRINGS
Army and Navy General Hospital
Leo N. Levi Memorial Hospital
St. Joseph's Hospital
JONESBORO
St. Bernard's Hospital
LITTLE ROCK
*Arkansas Children's Hospital
Baptist State Hospital
Little Rock City Hospital
Missouri Pacific Hospital
St. Vincent's Infirmary
NORTH LITTLE ROCK
Veterans' Administration Hospital
RUSSELLVILLE
*St. Mary's Hospital
TEXARKANA
Michael Meagher Memorial Hospital
St. Louis Southwestern Hospital

*Provisionally approved.

California

ALAMEDA
Alameda Sanatorium
ALHAMBRA
Alhambra Hospital
ARLINGTON
Riverside County Hospital
BAKERSFIELD
Mercy Hospital
BERKELEY
Alta Bates Hospital
Ernest V. Cowell Memorial Hospital, University of California
BURBANK
Burbank Hospital
COMPTON
Compton Sanitarium and Las Campanas Hospital
FORT BRAGG
Redwood Coast Hospital
FRENCH CAMP
*San Joaquin General Hospital
FRESNO
*Burnett Sanitarium
General Hospital of Fresno County
St. Agnes Hospital
GLENDALE
Glendale Sanitarium and Hospital
Physicians and Surgeons Hospital
HUNTINGTON PARK
Mission Hospital
LA JOLLA
Scripps Memorial Hospital
LIVERMORE
Arroyo Sanitarium
Veterans' Administration Hospital
LOMA LINDA
Loma Linda Sanitarium and Hospital
LONG BEACH
Harriman Jones Clinic and Hospital
Long Beach Community Hospital
St. Mary's Long Beach Hospital
Seaside Hospital
LOS ANGELES
California Hospital
Cedars of Lebanon Hospital
Children's Hospital
French Hospital
Golden State Hospital
Hollywood Clara Barton Memorial Hospital
Hospital of the Good Samaritan
Methodist Hospital of Southern California
Orthopedic Hospital
Queen of the Angels Hospital
St. Vincent's Hospital
Santa Fe Coast Lines Hospital
Veterans' Administration Hospital
White Memorial Hospital
MARE ISLAND
United States Naval Hospital
MONTEREY
Monterey Hospital
MONTEREY PARK
Garfield Hospital
NATIONAL CITY
Paradise Valley Sanitarium and Hospital
OAKLAND
Children's Hospital of the East Bay
East Oakland Hospital
Highland Hospital of Alameda County
Peralta Hospital
Providence Hospital
Samuel Merritt Hospital
ORANGE
Orange County General Hospital
St. Joseph Hospital
OXNARD
St. John's Hospital
PALO ALTO
Palo Alto Hospital
Veterans' Administration Hospital
PASADENA
Pasadena Hospital
POMONA
Pomona Valley Community Hospital
RIVERSIDE
Riverside Community Hospital
ROSS
Ross General Hospital
SACRAMENTO
Mater Misericordiæ Hospital
Sacramento Hospital
Sutter Hospital
SAN BERNARDINO
St. Bernardino's Hospital
San Bernardino County Charity Hospital
SAN DIEGO
Mercy Hospital
San Diego County General Hospital
United States Naval Hospital
SAN FERNANDO
Veterans' Administration Hospital
SAN FRANCISCO
Franklin Hospital
French Hospital
Hospital for Children
Letterman General Hospital
Mary's Help Hospital
Mount Zion Hospital
St. Francis Hospital
St. Joseph's Hospital
St. Luke's Hospital
St. Mary's Hospital
San Francisco Hospital
Shriners' Hospital for Crippled Children
Southern Pacific General Hospital
Stanford University Hospitals
United States Marine Hospital
University of California Hospitals
SANITARIUM
St. Helena Sanitarium and Hospital
SAN JOSE
O'Connor Sanitarium
San Jose Hospital
Santa Clara County Hospital
SAN LEANDRO
Fairmont Hospital of Alameda County
SAN LUIS OBISPO
*San Luis Obispo General Hospital
SAN MATEO
Community Hospital of San Mateo County
Mills Memorial Hospital
SAN PEDRO
San Pedro General Hospital
United States Naval Hospital Ship Relief
SANTA ANA
*Santa Ana Valley Hospital
SANTA BARBARA
St. Francis Hospital of Santa Barbara
Santa Barbara Cottage Hospital
Santa Barbara General Hospital
SANTA MONICA
Santa Monica Hospital
SOUTH SAN FRANCISCO
*South San Francisco Hospital
STOCKTON
St. Joseph's Home and Hospital
TALMAGE
*Mendocino State Hospital
TORRANCE
Jared Sidney Torrance Memorial Hospital
VENTURA
E. P. Foster Memorial Hospital
VETERANS HOME
Veterans Home of California
WESTWOOD
*Westwood Hospital
WOODLAND
Woodland Clinic Hospital

Colorado

BOULDER
Boulder-Colorado Sanitarium and Hospital
Community Hospital
COLORADO SPRINGS
Beth-El General Hospital
Cragmor Sanatorium
Glockner Sanatorium and Hospital
National Methodist Episcopal Sanatorium for Tuberculosis
St. Francis Hospital
DENVER
Beth Israel Hospital
Children's Hospital
Denver General Hospital
Mercy Hospital
*Mt. Airy Sanitarium
National Jewish Hospital
Porter Sanitarium and Hospital
Presbyterian Hospital of Colorado
St. Anthony's Hospital
St. Joseph's Hospital
St. Luke's Hospital

Sanatorium of the Jewish Consumptives' Relief Society
University of Colorado Hospitals
Colorado General Hospital
Colorado Psychopathic Hospital

DURANGO
Mercy Hospital

ENGLEWOOD
*Swedish National Sanatorium for Tuberculosis

FORT LYON
Veterans' Administration Hospital

GRAND JUNCTION
St. Mary's Hospital

GREELEY
Greeley Hospital

LA JUNTA
Atchison, Topeka and Santa Fe Railroad Hospital
*Mennonite Hospital and Sanitarium

LONGMONT
Longmont Hospital

PUEBLO
Corwin Hospital of the Colorado Fuel and Iron Company
Parkview Hospital
St. Mary Hospital
*Woodcroft Hospital

SALIDA
Denver and Rio Grande Western Hospital Association's Hospital
*Red Cross Hospital

STERLING
St. Benedict Hospital

TRINIDAD
Mt. San Rafael Hospital

WOODMEN
Modern Woodmen of America Sanatorium

Connecticut

BRIDGEPORT
Bridgeport Hospital
St. Vincent's Hospital

BRISTOL
Bristol Hospital

DANBURY
Danbury Hospital

DERBY
Griffin Hospital

GREENWICH
Greenwich Hospital

HARTFORD
Hartford Hospital
Mount Sinai Hospital
Municipal Hospital
St. Francis Hospital

MERIDEN
Meriden Hospital

MIDDLETOWN
Middlesex Hospital

NEW BRITAIN
New Britain General Hospital

NEW HAVEN
Grace Hospital
Hospital of St. Raphael
New Haven Hospital

NEWINGTON
*Newington Home for Crippled Children
Veterans' Administration Hospital

NEW LONDON
*Home Memorial Hospital
Lawrence and Memorial Associated Hospitals

NORWALK
Norwalk General Hospital

NORWICH
William W. Backus Hospital

PUTNAM
Day Kimball Hospital

SOUTH MANCHESTER
Manchester Memorial Hospital

STAMFORD
Stamford Hospital

TORRINGTON
Charlotte Hungerford Hospital

WATERBURY
St. Mary's Hospital
Waterbury Hospital

WILLIMANTIC
Windham Community Memorial Hospital

WINSTED
Litchfield County Hospital

Delaware

FARNHURST
Delaware State Hospital

LEWES
Beebe Hospital of Lewes

WILMINGTON
Delaware Hospital
Homeopathic Hospital
St. Francis Hospital
Wilmington General Hospital

District of Columbia

WASHINGTON
Central Dispensary and Emergency Hospital
Children's Hospital of the District of Columbia
Columbia Hospital for Women and Lying-in Asylum
Episcopal Eye, Ear, and Throat Hospital
Freedmen's Hospital
Gallinger Municipal Hospital
Garfield Memorial Hospital
Georgetown University Hospital
George Washington University Hospital
National Homeopathic Hospital
Providence Hospital
St. Elizabeth's Hospital
Sibley Memorial Hospital
United States Naval Hospital
Veterans' Administration Hospital
Walter Reed General Hospital
Washington Sanitarium and Hospital

Florida

CENTURY
Turberville Hospital

CLEARWATER
Morton F. Plant Endowed Hospital

DAYTONA BEACH
Halifax District Hospital

FORT LAUDERDALE
*Memorial Hospital

GAINESVILLE
Alachua County Hospital
University of Florida Infirmary

JACKSONVILLE
Brewster Hospital
Duval County Hospital
Riverside Hospital
St. Luke's Hospital
St. Vincent's Hospital

KEY WEST
United States Marine Hospital

LAKE CITY
Veterans' Administration Hospital

LAKELAND
Morrell Memorial Hospital

MIAMI
Dade County Hospital
James M. Jackson Memorial Hospital
Victoria Hospital

MIAMI BEACH
St. Francis Hospital

OCALA
Munroe Memorial Hospital

ORLANDO
*Orange General Hospital
*Orlando-Florida Sanitarium and Hospital

PENSACOLA
Pensacola Hospital
United States Naval Hospital

ST. AUGUSTINE
East Coast Hospital
Flagler Hospital

ST. PETERSBURG
City Hospitals (Mound Park—Mercy)
St. Anthony's Hospital
Veterans' Administration Hospital

TALLAHASSEE
*Florida Agricultural and Mechanical College Hospital

TAMPA
Centro Asturiano Hospital
Children's Hospital of Tampa
Tampa Municipal Hospital

WEST PALM BEACH
Good Samaritan Hospital

Georgia

ALBANY
Phoebe Putney Memorial Hospital

ATHENS
Athens General Hospital

ATLANTA
Crawford W. Long Memorial Hospital
Georgia Baptist Hospital
Grady Memorial Hospital
Henrietta Egleston Hospital for Children
Piedmont Hospital
St. Joseph's Infirmary
United States Penitentiary Hospital
Veterans' Administration Hospital
Wesley Memorial Hospital

AUGUSTA
University Hospital
Veterans' Administration Hospital
Wilhenford Hospital for Women and Children

CANTON
*Coker's Hospital

COLUMBUS
City Hospital

CUTHBERT
Patterson Hospital

DECATUR
Scottish Rite Hospital for Crippled Children

GAINESVILLE
Downey Hospital

MACON
Macon Hospital
Middle Georgia Sanatorium

MILLEN
Millen Hospital

PLAINS
Wise Sanitarium

ROME
Harbin Hospital
McCall Hospital

SAVANNAH
Central of Georgia Railway Hospital
United States Marine Hospital

THOMASVILLE
John D. Archbold Memorial Hospital

WAYCROSS
Atlantic Coast Lines Hospital
Ware County Hospital

Idaho

BOISE
St. Alphonsus Hospital
St. Luke's Hospital
Veterans' Administration Hospital

IDAHO FALLS
Idaho Falls Latter Day Saints Hospital

LEWISTON
St. Joseph's Hospital

NAMPA
Mercy Hospital

POCATELLO
Pocatello General Hospital
St. Anthony's Mercy Hospital

WALLACE
Providence Hospital

Illinois

ALTON
St. Joseph's Hospital

AURORA
Copley Hospital
St. Joseph Mercy Hospital

BERWYN
Berwyn Hospital

BLUE ISLAND
St. Francis Hospital

CAIRO
St. Mary's Infirmary

CHAMPAIGN
*Burnham City Hospital

CHICAGO
Albert Merritt Billings Hospital
Alexian Brothers Hospital
American Hospital
Augustana Hospital
Bethany Sanitarium and Hospital
Chicago Eye, Ear, Nose, and Throat Hospital
Chicago Lying-in Hospital and Dispensary
Chicago Memorial Hospital
Children's Memorial Hospital
Columbus Hospital
Cook County Hospital
Edgewater Hospital
Englewood Hospital
Evangelical Deaconess Hospital
Evangelical Hospital of Chicago
Frances E. Willard National Temperance Hospital
Garfield Park Hospital
Grant Hospital
Henrotin Hospital
Holy Cross Hospital
Hospital of St. Anthony de Padua
Illinois Central Hospital
Illinois Eye and Ear Infirmary
Illinois Masonic Hospital
Jackson Park Hospital
John B. Murphy Hospital
Lake View Hospital
Lewis Memorial Maternity Hospital
Lutheran Deaconess Home and Hospital
Lutheran Memorial Hospital
*Martha Washington Hospital
Mercy Hospital
Michael Reese Hospital
Misericordia Hospital and Home for Infants
Mother Cabrini Memorial Hospital
Mount Sinai Hospital
Municipal Contagious Disease Hospital
Municipal Tuberculosis Sanitarium
Passavant Memorial Hospital
Post-Graduate Hospital
Presbyterian Hospital
Provident Hospital
Ravenswood Hospital
Research and Educational Hospitals of the University of Illinois
Roseland Community Hospital
St. Anne's Hospital
St. Bernard's Hospital

St. Elizabeth's Hospital
St. Joseph's Hospital
St. Luke's Hospital
St. Mary of Nazareth Hospital
Shriners' Hospital for Crippled Children
South Chicago Community Hospital
South Shore Hospital
Swedish Covenant Hospital
United States Marine Hospital
University Hospital of Chicago
Washington Boulevard Hospital
Wesley Memorial Hospital
*West Side Hospital
Women and Children's Hospital
Woodlawn Hospital

DANVILLE

Lake View Hospital
St. Elizabeth's Hospital
Veterans' Administration Hospital

DECATUR

Decatur and Macon County Hospital
Wabash Employees' Hospital

DE KALB

De Kalb Public Hospital

DIXON

Dixon Public Hospital

EAST ST. LOUIS

Christian Welfare Hospital
St. Mary's Hospital

ELGIN

Sherman Hospital

EVANSTON

Evanston Hospital
St. Francis Hospital

EVERGREEN PARK

Little Company of Mary Hospital

FREEPORT

Evangelical Deaconess Hospital
St. Francis Hospital

GALESBURG

Galesburg Cottage Hospital

GENEVA

Community Hospital

GRANITE CITY

St. Elizabeth's Hospital

HARVEY

Ingalls Memorial Hospital

HIGHLAND PARK

Highland Park Hospital

HINES

Veterans' Administration Hospital

HINSDALE

*Hinsdale Sanitarium and Hospital

JACKSONVILLE

Our Savior's Hospital
Passavant Memorial Hospital

JOLIET

St. Joseph's Hospital
Silver Cross Hospital

KANKAKEE

St. Mary Hospital

KEWANEE

Kewanee Public Hospital
St. Francis Hospital

MELROSE PARK

Westlake Hospital

MOLINE

Lutheran Hospital
Moline Public Hospital

MONMOUTH

Monmouth Hospital

MURPHYSBORO

St. Andrew's Hospital

NORTH CHICAGO

Veterans' Administration Hospital

OAK PARK

Oak Park Hospital
West Suburban Hospital

OLNEY

Olney Sanitarium

OTTAWA

Ryburn Memorial Hospital

PANA

Huber Memorial Hospital

PEORIA

Peoria Municipal Tuberculosis Sanitarium
*St. Francis Hospital

QUINCY

Blessing Hospital
St. Mary's Hospital

ROCKFORD

Rockford Hospital
St. Anthony's Hospital
Swedish-American Hospital

ROCK ISLAND

St. Anthony's Hospital

SPRINGFIELD

Palmer Tuberculosis Sanatorium
*Springfield Hospital

STERLING

Public Hospital of the City of Sterling

SYCAMORE

*Syramore Municipal Hospital

WAUKEGAN

St. Therese's Hospital
Victory Memorial Hospital

Indiana

ANDERSON

St. John's Hospital

BEECH GROVE

St. Francis Hospital

CROWN POINT

Lake County Tuberculosis Sanatorium

EAST CHICAGO

St. Catherine's Hospital

EVANSVILLE

Boehne Tuberculosis Hospital
Protestant Deaconess Hospital
St. Mary's Hospital
United States Marine Hospital
Walker Hospital

FORT WAYNE

Lutheran Hospital of Fort Wayne
Methodist Episcopal Hospital
St. Joseph's Hospital

FRANKFORT

Clinton County Hospital

GARY

Illinois Steel Company, Gary Hospital
Methodist Episcopal Hospital
St. Mary's Mercy Hospital

HAMMOND

St. Margaret's Hospital

INDIANAPOLIS

Indianapolis City Hospital
Indiana University Hospitals
Robert W. Long Hospital
James Whitcomb Riley Hospital for Children
William H. Coleman Hospital for Women
Methodist Episcopal Hospital
St. Vincent's Hospital
Veterans' Administration Hospital

JEFFERSONVILLE

Clark County Memorial Hospital

LA FAYETTE

La Fayette Home Hospital
St. Elizabeth's Hospital

MARION

Grant County Hospital
Veterans' Administration Hospital

MICHIGAN CITY

Clinic Hospital
St. Anthony's Hospital

MISHAWAKA

St. Joseph's Hospital

MUNCIE

Ball Memorial Hospital

NEW ALBANY

St. Edward's Hospital

NEWCASTLE

*Henry County Hospital

PERU

*Wabash Railroad Employees' Hospital

PRINCETON

Methodist Episcopal Hospital

RICHMOND

Reid Memorial Hospital

SOUTH BEND

Epworth Hospital
*Healthwin Hospital
St. Joseph Hospital

SULLIVAN

Mary Sherman Hospital

TERRE HAUTE

St. Anthony's Hospital
Union Hospital

Iowa

AMES

Iowa State College Hospital

BURLINGTON

Burlington Protestant Hospital
Mercy Hospital

CARROLL

*St. Anthony Hospital

CEDAR FALLS

*Sartori Memorial Hospital

CEDAR RAPIDS

Mercy Hospital
St. Luke's Methodist Hospital

CENTERVILLE

St. Joseph's Mercy Hospital

CLINTON

Jane Lamb Memorial Hospital
St. Joseph Mercy Hospital

COUNCIL BLUFFS

Jennie Edmundson Memorial Hospital
Mercy Hospital

DAVENPORT

Mercy Hospital
St. Luke's Hospital

DECORAH

*Decorah Hospital

DES MOINES

*Iowa Lutheran Hospital
Iowa Methodist Hospital
Mercy Hospital
Polk County Public Hospitals
Broadlawns Division
General Division

DUBUQUE

Finley Hospital

FORT DODGE

*Lutheran Hospital
St. Joseph Mercy Hospital

FORT MADISON

*Atchison, Topeka, and Santa Fe Hospital

GRINNELL

*Community Hospital

HAMPTON

Lutheran Hospital

IOWA CITY

*Mercy Hospital
State University of Iowa, University Hospitals

KEOKUK

Graham Protestant Hospital
St. Joseph's Hospital

KNOXVILLE

Veterans' Administration Hospital

LE MARS

Sacred Heart Hospital

MASON CITY

Park Hospital
St. Joseph's Mercy Hospital

NEW HAMPTON

St. Joseph's Hospital

OTTUMWA

*Ottumwa Hospital
St. Joseph's Hospital
*Sunnyslope Sanatorium

SIOUX CITY

*Lutheran Hospital
Methodist Hospital
St. Joseph's Mercy Hospital
St. Vincent's Hospital

WASHINGTON

Washington County Hospital

WATERLOO

Allen Memorial Hospital
*Presbyterian Hospital
St. Francis Hospital

WAVERLY

St. Joseph Mercy Hospital

Kansas

ARKANSAS CITY

*Mercy Hospital

BELOIT

Community Hospital

CONCORDIA

St. Joseph's Hospital

DODGE CITY

St. Anthony's Hospital

EL DORADO

Susan B. Allen Memorial Hospital

ELLSWORTH

Ellsworth Hospital

FORT LEAVENWORTH

United States Penitentiary Annex Hospital

FORT SCOTT

Mercy Hospital

GARDEN CITY

*St. Catherine's Hospital

GREAT BEND

St. Rose Hospital

HALSTEAD

Halstead Hospital

HAYS

Hays Protestant Hospital
St. Anthony's Hospital

HUTCHINSON

Grace Hospital
St. Elizabeth's Mercy Hospital

INDEPENDENCE

*Mercy Hospital

KANSAS CITY

Bell Memorial Hospital
Bethany Methodist Hospital
Providence Hospital
St. Margaret's Hospital

LEAVENWORTH

St. John's Hospital
United States Penitentiary Hospital
Veterans' Administration Hospital

LIBERAL

Epworth Hospital

MULVANE

Atchison, Topeka, and Santa Fe Hospital

NEWTON

Axtell Christian Hospital
Bethel Deaconess Hospital

PARSONS

Missouri-Kansas-Texas Railroad Employes' Hospital

PITTSBURG

Mt. Carmel Hospital

SABETHA

St. Anthony Murdock Memorial Hospital

SALINA

St. John's Hospital

TOPEKA

Atchison, Topeka, and Santa Fe Hospital
Christ's Hospital
Jane C. Stormont Hospital
St. Francis Hospital

WELLINGTON

Hatcher Hospital

WICHITA

St. Francis Hospital
Wesley Hospital
Wichita Hospital

*Provisionally approved.

WINFIELD
St. Mary's Hospital
William Newton Memorial Hospital

Kentucky

BEREA
Berea College Hospital
BOWLING GREEN
*City Hospital
COVINGTON
St. Elizabeth's Hospital
DAYTON
*Speers Memorial Hospital
GLASGOW
Community Hospital
JENKINS
Jenkins Hospital
LEXINGTON
Good Samaritan Hospital
St. Joseph's Hospital
Shriners' Hospital for Crippled Children—Mobile Unit
Veterans' Administration Hospital
LOUISVILLE
Children's Free Hospital
Jewish Hospital
John N. Norton Memorial Infirmary
Kentucky Baptist Hospital
Kosair Crippled Children Hospital
Louisville City Hospital
Methodist Episcopal Deaconess Hospital
St. Anthony's Hospital
St. Joseph's Infirmary
Sts. Mary and Elizabeth Hospital
United States Marine Hospital
LYNCH
Lynch Hospital of the United States Coal and Coke Company
MURRAY
William Mason Memorial Hospital
OUTWOOD
Veterans' Administration Hospital
PADUCAH
Illinois Central Hospital
Riverside Hospital
PARIS
W. W. Massie Memorial Hospital
PIKEVILLE
*Methodist Hospital of Kentucky

Louisiana

ALEXANDRIA
Baptist Hospital
Veterans' Administration Hospital
BATON ROUGE
*Baton Rouge General Hospital
Our Lady of the Lake Hospital
BOGALUSA
Elizabeth Sullivan Memorial Hospital
CARVILLE
United States Marine Hospital
HAYNESVILLE
Haynesville Hospital
JACKSON
Parker Hospital of the East Louisiana Hospital for Insane
LAKE CHARLES
St. Patrick's Sanitarium
MONROE
St. Francis Sanitarium
Vaughan-Wright-Bendel Clinic Hospital
NEW ORLEANS
Eye, Ear, Nose, and Throat Hospital
Flint-Goodridge Hospital of Dillard University
French Hospital
Hotel Dieu
Illinois Central Hospital
Mercy Hospital—Soniat Memorial
Southern Baptist Hospital
State of Louisiana Charity Hospital
Touro Infirmary
United States Marine Hospital
PINEVILLE
Fuqua Memorial Hospital of the Central Louisiana State Hospital for the Insane
SHREVEPORT
Highland Sanitarium
North Louisiana Sanitarium
Shreveport Charity Hospital
Shreveport Sanitarium and T. E. Schumpert Memorial Hospital
Shriners' Hospital for Crippled Children
Tri-State Hospital

Maine

AUGUSTA
*Augusta General Hospital
Veterans' Administration Hospital
BANGOR
Eastern Maine General Hospital
BATH
*Bath City Hospital
BELFAST
Waldo County General Hospital
FAIRFIELD
*Central Maine Sanatorium
FARMINGTON
Franklin County Memorial Hospital
GARDINER
Gardiner General Hospital
LEWISTON
Central Maine General Hospital
St. Mary's General Hospital
PORTLAND
Children's Hospital
Maine Eye and Ear Infirmary
Maine General Hospital
*Queen's Hospital
St. Barnabas Hospital
State Street Hospital
United States Marine Hospital
ROCKLAND
*Knox County General Hospital
RUMFORD
Rumford Community Hospital
SANFORD
Henrietta D. Goodall Hospital
WATERVILLE
Sisters' Hospital
Thayer Hospital

Maryland

ANNAPOLIS
United States Naval Hospital
BALTIMORE
Baltimore City Hospitals
*Baltimore Eye, Ear, Nose and Throat Charity Hospital
Bon Secours Hospital
Children's Hospital
Church Home and Infirmary
Franklin Square Hospital
Hospital for the Women of Maryland
Howard A. Kelly Hospital
Johns Hopkins Hospital
Maryland General Hospital
Mercy Hospital
Provident Hospital and Free Dispensary
St. Agnes Hospital
St. Joseph's Hospital
Sinai Hospital
South Baltimore General Hospital
Union Memorial Hospital
United States Marine Hospital
University Hospital of the University of Maryland
Volunteers of America Hospital
West Baltimore General Hospital
CAMBRIDGE
Cambridge-Maryland Hospital
CUMBERLAND
Allegany Hospital of the Sisters of Charity
Memorial Hospital
EASTON
*Emergency Hospital
FREDERICK
Frederick City Hospital
HAGERSTOWN
Washington County Hospital
HILLSDALE
James Lawrence Kernan Hospital
PERRY POINT
Veterans' Administration Hospital
SALISBURY
Peninsula General Hospital

Massachusetts

ADAMS
W. B. Plunkett Memorial Hospital
AMESBURY
Amesbury Hospital
ARLINGTON
Symmes Arlington Hospital
ATTLEBORO
Sturdy Memorial Hospital
AYER
Community Memorial Hospital
BEDFORD
Veterans' Administration Hospital
BEVERLY
Beverly Hospital
BOSTON
Beth Israel Hospital
Boston City Hospital
Boston Floating Hospital
Boston Lying-in Hospital
Carney Hospital
Children's and Infants' Hospital
Collis P. Huntington Memorial Hospital
Emerson Hospital
Evangeline Booth Maternity Hospital and Home
Faulkner Hospital
Harley Private Hospital
Hart Private Hospital
House of the Good Samaritan
Long Island Hospital
Massachusetts Eye and Ear Infirmary
Massachusetts General Hospital
Massachusetts Memorial Hospitals
Massachusetts Women's Hospital
New England Baptist Hospital
New England Deaconess Hospital
New England Hospital for Women and Children
Peter Bent Brigham Hospital
Robert Breck Brigham Hospital
St. Elizabeth's Hospital
St. Margaret's and St. Mary's Lying-in Hospitals
Salvation Army Roxbury Hospital and Clinic
BROCKTON
Brockton Hospital
Goddard Hospital
BROOKLINE
*Board of Health Hospital
Brooks Hospital
Free Hospital for Women
CAMBRIDGE
Cambridge City Hospital
Cambridge Hospital
CHELSEA
Captain John Adams Hospital of Soldiers' Home in Massachusetts
Chelsea Memorial Hospital
United States Marine Hospital
United States Naval Hospital
CLINTON
Clinton Hospital
CONCORD
Emerson Hospital in Concord
EVERETT
Whidden Memorial Hospital
FALL RIVER
Fall River General Hospital
St. Anne's Hospital
Truesdale Hospital
Union Hospital in Fall River
FITCHBURG
Burbank Hospital
FRAMINGHAM
Framingham-Union Hospital
GARDNER
Henry Heywood Memorial Hospital
GLOUCESTER
Addison Gilbert Hospital
GREENFIELD
Franklin County Public Hospital
HAVERHILL
Municipal Hospitals
HOLDEN
Holden District Hospital
HOLYOKE
Holyoke Hospital
Providence Hospital
LAWRENCE
Lawrence General Hospital
LEOMINSTER
Leominster Hospital
LOWELL
Lowell General Hospital
St. John's Hospital
St. Joseph's Hospital
LYNN
Lynn Hospital
MALDEN
Malden Hospital
MARLBOROUGH
*Marlborough Hospital
MEDFORD
Lawrence Memorial Hospital
MELROSE
Melrose Hospital
New England Sanitarium and Hospital
MIDDLEBOROUGH
Lakeville State Sanatorium
MILFORD
*Milford Hospital
MILTON
Milton Hospital and Convalescent Home
MONTAGUE CITY
Farren Memorial Hospital
NATICK
Leonard Morse Hospital
NEW BEDFORD
St. Luke's Hospital
NEWBURYPORT
Anna Jaques Hospital
Newburyport Homeopathic Hospital
NEWTON LOWER FALLS
Newton Hospital
NORFOLK
Hospital of the State Prison Colony of Norfolk
NORTH ADAMS
North Adams Hospital
NORTHAMPTON
Cooley Dickinson Hospital
Veterans' Administration Hospital

NORTH WILMINGTON
North Reading State Sanatorium
NORWOOD
Norwood Hospital
PALMER
Wing Memorial Hospital
PEABODY
Josiah B. Thomas Hospital
PITTSFIELD
House of Mercy Hospital
St. Luke's Hospital
QUINCY
Quincy City Hospital
RUTLAND
Rutland State Sanatorium
Veterans' Administration Hospital
SALEM
North Shore Babies' Hospital
Salem Hospital
SOMERVILLE
Somerville Hospital
SOUTHBRIDGE
Harrington Memorial Hospital
SOUTH WEYMOUTH
Weymouth Hospital
SPRINGFIELD
Mercy Hospital
Shriners' Hospital for Crippled Children
Springfield Hospital
Wesson Maternity Hospital
Wesson Memorial Hospital
TAUNTON
Morton Hospital
VINEYARD HAVEN
United States Marine Hospital
WALTHAM
Waltham Hospital
WARE
Mary Lane Hospital
WEBSTER
Webster District Hospital
WESTFIELD
Noble Hospital
Westfield State Sanatorium
WINCHESTER
Winchester Hospital
WOBURN
Charles Choate Memorial Hospital
WORCESTER
Belmont Hospital
City Hospital
Fairlawn Hospital
Memorial Hospital
St. Vincent Hospital
Worcester Hahnemann Hospital
WRENTHAM
Pondville Hospital at Norfolk

Michigan

ALBION
James W. Sheldon Memorial Hospital
ANN ARBOR
St. Joseph's Mercy Hospital
University Hospital
BATTLE CREEK
Battle Creek Sanitarium
Leila Y. Post Montgomery Hospital
Nichols Memorial Hospital
BAY CITY
Mercy Hospital
BENTON HARBOR
Mercy Hospital
CADILLAC
Mercy Hospital
CALUMET
*Calumet and Hecla Mining Company Hospital
CAMP CUSTER
Veterans' Administration Hospital
DETROIT
Charles Godwin Jennings Hospital
Children's Hospital of Michigan
*Delray General Hospital
*Detroit Eye, Ear, Nose, and Throat Hospital
*Dunbar Memorial Hospital
*East Side General Hospital
Evangelical Deaconess Hospital
Florence Crittenton Hospital and Home
Grace Hospital
Harper Hospital
Henry Ford Hospital
Herman Kiefer Hospital
Jefferson Clinic and Diagnostic Hospital
*Lincoln Hospital
Michigan Mutual Hospital
Providence Hospital
Receiving Hospital
St. Joseph's Mercy Hospital
St. Mary's Hospital
United States Marine Hospital
Woman's Hospital
ELOISE
Eloise Infirmary
FLINT
Hurley Hospital
Women's Hospital
GOODRICH
Goodrich General Hospital
GRAND RAPIDS
Blodgett Memorial Hospital
Butterworth Hospital
St. Mary's Hospital
GRAYLING
*Mercy Hospital
GROSSE POINTE
Cottage Hospital of Grosse Pointe
HAMTRAMCK
*St. Francis Hospital
HANCOCK
St. Joseph's Hospital
HIGHLAND PARK
Highland Park General Hospital
IRONWOOD
Grand View Hospital
ISHPEMING
Ishpeming Hospital
JACKSON
Mercy Hospital
W. A. Foote Memorial Hospital
KALAMAZOO
Borgess Hospital
Bronson Methodist Hospital
LANSING
Edward W. Sparrow Hospital
St. Lawrence Hospital
MARQUETTE
St. Luke's Hospital
MONROE
*Mercy Hospital
MT. CLEMENS
St. Joseph Sanitarium and Hospital
MUSKEGON
Hackley Hospital
Mercy Hospital
Muskegon County Sanatorium
NILES
*Pawating Hospital
OWOSSO
Memorial Hospital
PONTIAC
Pontiac General Hospital
St. Joseph Mercy Hospital
SAGINAW
Saginaw County Contagious Hospital
Saginaw General Hospital
St. Luke's Hospital
St. Mary's Hospital
ST. JOHNS
Clinton Memorial Hospital
SAULT STE. MARIE
Chippewa County War Memorial Hospital
THREE RIVERS
*Three Rivers Hospital
WYANDOTTE
Wyandotte General Hospital

Minnesota

ALBERT LEA
*Naeve Hospital
ALEXANDRIA
Douglas County Hospital
BRAINERD
St. Joseph's Hospital
CROOKSTON
Bethesda Hospital
St. Vincent's Hospital
DULUTH
St. Luke's Hospital
St. Mary's Hospital
EVELETH
More Hospital
FERGUS FALLS
*George B. Wright Memorial Hospital
St. Luke's Hospital
GRACEVILLE
Western Minnesota Hospital
HIBBING
Adams Hospital
Rood Hospital
LITTLE FALLS
St. Gabriel's Hospital
MANKATO
Immanuel Hospital
St. Joseph's Hospital
MINNEAPOLIS
Abbott Hospital
Asbury Hospital
Eitel Hospital
Fairview Hospital
Hill Crest Surgical Hospital
Lutheran Deaconess Home and Hospital
Maternity Hospital
Minneapolis General Hospital
Northwestern Hospital
St. Andrew's Hospital
St. Barnabas Hospital
St. Mary's Hospital
Shriners' Hospital for Crippled Children
Swedish Hospital
University Hospital
Veterans' Administration Hospital
NOPEMING
Nopeming Sanatorium
OAK TERRACE
Glen Lake Sanatorium
RED WING
St. John's Hospital
ROCHESTER
Colonial Hospital
Kahler Hospital
St. Mary's Hospital
Worrell Hospital
ST. CLOUD
St. Cloud Hospital
Veterans' Administration Hospital
ST. PAUL
Ancker Hospital
Bethesda Hospital
Charles T. Miller Hospital
Children's Hospital
Gillette State Hospital for Crippled Children
Midway Hospital
Mounds Park Sanitarium
Northern Pacific Beneficial Association Hospital
St. John's Hospital
St. Joseph's Hospital
St. Luke's Hospital
STILLWATER
Lakeview Memorial Hospital
THIEF RIVER FALLS
St. Luke's Hospital
WADENA
*Wesley Hospital
WARREN
Warren Hospital
WILLMAR
Willmar Hospital
WINONA
Winona General Hospital

Mississippi

BILOXI
Biloxi Hospital
BROOKHAVEN
*King's Daughters' Hospital
CENTREVILLE
Field Memorial Hospital
COLUMBIA
Columbia Clinic Hospital
CORINTH
McRae Hospital
ELECTRIC MILLS
George C. Hixon Memorial Hospital
GREENVILLE
King's Daughters' Hospital (White)
GULFPORT
King's Daughters' Hospital
Veterans' Administration Hospital
HATTIESBURG
South Mississippi Infirmary
HOUSTON
Houston Hospital
JACKSON
Jackson Infirmary
Mississippi Baptist Hospital
MERIDIAN
*Anderson Infirmary
*Matty Hersee Hospital
Meridian Sanitarium
Rush's Infirmary
NATCHEZ
Chamberlain-Rice Hospital
Natchez Charity Hospital
Natchez Sanatorium
OXFORD
*Oxford Hospital
SANATORIUM
Mississippi State Tuberculosis Sanatorium
STATE COLLEGE
James Z. George Memorial Hospital
TUPELO
Tupelo Hospital
VICKSBURG
Vicksburg Hospital
Vicksburg Infirmary
Vicksburg Sanitarium and Crawford Street Hospital
WINONA
Winona Infirmary

Missouri

BOONVILLE
St. Joseph's Hospital
CAPE GIRARDEAU
St. Francis Hospital
Southeast Missouri Hospital
CARTHAGE
McCune-Brooks Hospital
CLAYTON
St. Louis County Hospital
COLUMBIA
Boone County Hospital
University Hospitals, University of Missouri
EXCELSIOR SPRINGS
Veterans' Administration Hospital
HANNIBAL
Levering Hospital
St. Elizabeth's Hospital
INDEPENDENCE
Independence Sanitarium
JEFFERSON BARRACKS
Veterans' Administration Hospital

*Provisionally approved.

JEFFERSON CITY
Missouri State Prison Hospital
St. Mary's Hospital
JOPLIN
Freeman Hospital
St. John's Hospital
KANSAS CITY
Children's Mercy Hospital
Kansas City General Hospital
Kansas City General Mospital (Colored Division)
Menorah Hospital
Research Hospital
St. Joseph Hospital
St. Luke's Hospital
St. Mary's Hospital
Trinity Lutheran Hospital
Wheatley-Provident Hospital
LOUISIANA
*Pike County Hospital
MARYVILLE
St. Francis Hospital
MOBERLY
Wabash Employes' Hospital
ST. CHARLES
St. Joseph's Hospital
ST. JOSEPH
Missouri Methodist Hospital
St. Joseph's Hospital
ST. LOUIS
Alexian Brothers Hospital
Barnard Free Skin and Cancer Hospital
Barnes Hospital
Bethesda Hospital
Christian Hospital
City Sanitarium
De Paul Hospital
Evangelical Deaconess Home and Hospital
Firmin Desloge Hospital
Frisco Employes' Hospital
Isolation Hospital
Jewish Hospital of St. Louis
Lutheran Hospital
Missouri Baptist Hospital
Missouri Pacific Hospital
Mount St. Rose Sanatorium
Robert Koch Hospital
St. Anthony's Hospital
St. John's Hospital
St. Louis Children's Hospital
St. Louis City Hospital
*St. Louis City Hospital No. 2
St. Louis Maternity Hospital
St. Luke's Hospital
St. Mary's Hospital
St. Mary's Infirmary
Shriners' Hospital for Crippled Children
United States Marine Hospital
SPRINGFIELD
Burge Hospital
St. John's Hospital
Springfield Baptist Hospital

Montana

ANACONDA
St. Ann's Hospital
BILLINGS
Billings Deaconess Hospital
St. Vincent's Hospital
BOZEMAN
*Bozeman Deaconess Hospital
BUTTE
Murray Hospital
St. James Hospital
FORT HARRISON
Veterans' Administration Hospital
GLENDIVE
Northern Pacific Beneficial Association Hospital
GREAT FALLS
Columbus Hospital
Montana Deaconess Hospital
HAVRE
Kennedy Deaconess Hospital
Sacred Heart Hospital
HELENA
St. John's Hospital
St. Peter's Hospital
KALISPELL
Kalispell General Hospital
LEWISTOWN
St. Joseph's Hospital
MILES CITY
Holy Rosary Hospital
MISSOULA
Northern Pacific Beneficial Association Hospital
St. Patrick's Hospital
Thornton Hospital

Nebraska

ALLIANCE
St. Joseph's Hospital
BEATRICE
Lutheran Hospital
COLUMBUS
St. Mary's Hospital
FALLS CITY
Falls City Hospital
GRAND ISLAND
St. Francis Hospital
HASTINGS
Mary Lanning Memorial Hospital
LINCOLN
Bryan Memorial Hospital
Lincoln General Hospital
St. Elizabeth's Hospital
Veterans' Administration Hospital
McCOOK
St. Catherine of Sienna Hospital
OMAHA
Bishop Clarkson Memorial Hospital
Creighton Memorial, St. Joseph's Hospital
Douglas County Hospital
Evangelical Covenant Hospital
Immanuel Hospital
Nebraska Methodist Episcopal Hospital
St. Catherine's Hospital
University of Nebraska Hospital
SCOTTSBLUFF
*West Nebraska Methodist Episcopal Hospital

Nevada

EAST ELY
Steptoe Valley Hospital
ELKO
Elko General Hospital
RENO
St. Mary's Hospital

New Hampshire

BERLIN
Hospital St. Louis
CLAREMONT
Claremont General Hospital
CONCORD
Margaret Pillsbury General Hospital
New Hampshire Memorial Hospital
DOVER
Wentworth Hospital
EXETER
*Exeter Hospital
GRASMERE
Hillsborough County General Hospital
HANOVER
Mary Hitchcock Memorial Hospital
KEENE
Elliot Community Hospital
LACONIA
Laconia Hospital
MANCHESTER
Balch Hospital
Elliot Hospital
L'Hôpital De Notre Dame De Lourdes
Sacred Heart Hospital
NASHUA
Nashua Memorial Hospital
St. Joseph's Hospital
PETERBOROUGH
Peterborough Hospital
PORTSMOUTH
Portsmouth Hospital
United States Naval Hospital

New Jersey

ATLANTIC CITY
Atlantic City Hospital
BAYONNE
Bayonne Hospital and Dispensary
BOUND BROOK
Bound Brook Hospital
BRIDGETON
Bridgeton Hospital
CAMDEN
Cooper Hospital
West Jersey Homeopathic Hospital
EAST ORANGE
Homeopathic Hospital of Essex County
ELIZABETH
Alexian Brothers Hospital
Elizabeth General Hospital and Dispensary
St. Elizabeth Hospital
ENGLEWOOD
Englewood Hospital
FRANKLIN
*Franklin Hospital
HACKENSACK
Hackensack Hospital
HOBOKEN
St. Mary's Hospital
IRVINGTON
Irvington General Hospital
JERSEY CITY
Christ Hospital
Jersey City Hospital
Margaret Hague Maternity Hospital
St. Francis Hospital
KEARNY
West Hudson Hospital
LONG BRANCH
Monmouth Memorial Hospital
LYONS
Veterans' Administration Hospital
MONTCLAIR
Montclair Community Hospital
Mountainside Hospital
St. Vincent's Hospital
MORRISTOWN
All Souls Hospital
Morristown Memorial Hospital
MOUNT HOLLY
Burlington County Hospital
NEPTUNE
Raleigh Fitkin-Paul Morgan Memorial Hospital
NEWARK
Babies' Hospital
Hospital and Home for Crippled Children
Hospital for Women and Children
Hospital of St. Barnabas
Newark Beth Israel Hospital
Newark City Hospital
Newark Eye and Ear Infirmary
Newark Memorial Hospital
Presbyterian Hospital
St. James Hospital
St. Michael's Hospital
NEW BRUNSWICK
Middlesex General Hospital
St. Peter's General Hospital
NEWTON
*Newton Hospital
ORANGE
New Jersey Orthopedic Hospital and Dispensary
Orange Memorial Hospital
St. Mary's Hospital
PASSAIC
Passaic General Hospital
St. Mary's Hospital
PATERSON
Nathan and Miriam Barnert Memorial Hospital
Paterson General Hospital
St. Joseph's Hospital
PERTH AMBOY
Perth Amboy City Hospital
PHILLIPSBURG
*Warren Hospital
PLAINFIELD
Muhlenberg Hospital
PRINCETON
Princeton Hospital
RAHWAY
Rahway Memorial Hospital
RIDGEWOOD
Bergen County Hospital
SECAUCUS
Hudson County Hospital
SOMERVILLE
Somerset Hospital
SUMMIT
Overlook Hospital
TEANECK
Holy Name Hospital
TRENTON
Mercer Hospital
New Jersey State Hospital
St. Francis Hospital
*Trenton Municipal Colony Hospitals
William McKinley Memorial Hospital
VERONA
Essex Mountain Sanatorium
VINELAND
Newcomb Hospital
WEEHAWKEN
*North Hudson Hospital

New Mexico

ALBUQUERQUE
Atchison, Topeka and Santa Fe Hospital
St. Joseph Sanatorium and Hospital
*Southwestern Presbyterian Sanatorium and Hospital
Veterans' Administration Hospital
CLOVIS
*Atchison, Topeka and Santa Fe Hospital
FORT BAYARD
Veterans' Administration Hospital
FORT STANTON
United States Marine Hospital
GALLUP
St. Mary's Hospital
RATON
*New Mexico Miners' Hospital
ROSWELL
St. Mary's Hospital
SANTA FE
St. Vincent Hospital and Sanatorium

New York

ALBANY
Albany Hospital
Anthony N. Brady Maternity Home
*Child's Hospital
Memorial Hospital
St. Peter's Hospital
AMSTERDAM
Amsterdam City Hospital
St. Mary's Hospital
AUBURN
Auburn City Hospital

BATAVIA
St. Jerome's Hospital
*Woman's Hospital

BATH
Veterans' Administration Hospital

BAY SHORE
Southside Hospital

BINGHAMTON
Binghamton City Hospital

BRONX
Veterans' Administration Hospital

BRONXVILLE
Lawrence Hospital

BROOKLYN
Bay Ridge Sanitarium
Beth-El Hospital
Beth Moses Hospital
Brooklyn Eye and Ear Hospital
Brooklyn Hospital
Bushwick Hospital
Caledonian Hospital of the City of New York
Carson C. Peck Memorial Hospital
Coney Island Hospital
Cumberland Hospital
Greenpoint Hospital
Hospital of the Holy Family
House of St. Giles the Cripple
Israel-Zion Hospital
Jewish Hospital of Brooklyn
Kings County Hospital
Kingston Avenue Hospital
Long Island College Hospital
Lutheran Hospital
Methodist Episcopal Hospital
Norwegian Lutheran Deaconesses' Home and Hospital
Prospect Heights Hospital and Brooklyn Maternity
St. Catherine's Hospital
St. John's Hospital
St. Mary's Hospital of the City of Brooklyn
St. Peter's Hospital
Wyckoff Heights Hospital of Brooklyn

BUFFALO
Buffalo City Hospital
Buffalo Columbus Hospital
Buffalo General Hospital
Buffalo Hospital of the Sisters of Charity
Children's Hospital of Buffalo
Deaconess Hospital
Emergency Hospital of the Sisters of Charity
Memorial Hospital of Buffalo
Mercy Hospital
Millard Fillmore Hospital
St. Mary's Maternity Hospital
United States Marine Hospital

CAMBRIDGE
Mary McClellan Hospital

CANANDAIGUA
Frederick Ferris Thompson Hospital
Veterans' Administration Hospital

CASTLE POINT
Veterans' Administration Hospital

CLIFTON SPRINGS
Clifton Springs Sanitarium and Clinic

COHOES
Cohoes Hospital

COOPERTOWN
Mary Imogene Bassett Hospital

CORNING
*Corning Hospital

CORNWALL
Cornwall Hospital

CORTLAND
*Cortland County Hospital

DOBBS FERRY
Dobbs Ferry Hospital

ELLIS ISLAND
United States Marine Hospital

ELMIRA
Arnot-Ogden Memorial Hospital
St. Joseph's Hospital

ENDICOTT
Ideal Hospital

FAR ROCKAWAY
St. Joseph's Hospital

FLUSHING
Flushing Hospital and Dispensary

GENEVA
Geneva General Hospital

GLEN COVE
North Country Community Hospital

GLENS FALLS
Glens Falls Hospital

GLOVERSVILLE
Nathan Littauer Hospital

GOUVERNEUR
*Stephen B. Van Duzee Hospital

HORNELL
Bethesda Hospital
St. James Mercy Hospital

HUDSON
Hudson City Hospital

ITHACA
Tompkins County Memorial Hospital

JAMAICA
Mary Immaculate Hospital
Queensboro Hospital

JAMESTOWN
Jamestown General Hospital
Woman's Christian Association Hospital

JOHNSON CITY
Charles S. Wilson Memorial Hospital

KINGSTON
Benedictine Hospital
Kingston Hospital

LACKAWANNA
Moses Taylor Hospital
Our Lady of Victory Hospital

LAKE KUSHAQUA
Stony Wold Sanatorium

LITTLE FALLS
Little Falls Hospital

LONG ISLAND CITY
St. John's Long Island City Hospital

LOOMIS
Loomis Sanatorium

MALONE
Alice Hyde Memorial Hospital

MEDINA
*Medina Memorial Hospital

MIDDLETOWN
Elizabeth A. Horton Memorial Hospital

MINEOLA
Nassau Hospital

MT. KISCO
Northern Westchester Hospital

MT. MCGREGOR
Metropolitan Life Insurance Co. Sanatorium

MOUNT VERNON
Mount Vernon Hospital

NEWBURGH
St. Luke's Hospital of Newburgh, N. Y.

NEW DORP BEACH, S. I.
St. John's Guild Seaside Hospital

NEW ROCHELLE
New Rochelle Hospital

NEW YORK CITY
Babies' Hospital of the City of New York
Beekman Street Hospital
Bellevue Hospital
Beth David Hospital
Beth Israel Hospital Medical Center
Booth Memorial Hospital
*Broad Street Hospital
Bronx Hospital
Central and Neurological Hospital
Columbus Hospital
Columbus Hospital Extension
Community Hospital
Doctors Hospital
Fifth Avenue Hospital
Fordham Hospital
French Benevolent Society Hospital
Gouverneur Hospital
*Harlem Eye and Ear Hospital
Harlem Hospital
Herman Knapp Memorial Eye Hospital
Hospital for Joint Diseases
Hospital for the Ruptured and Crippled
Hospital of the Rockefeller Institute for Medical Research
Jewish Memorial Hospital
Knickerbocker Hospital
Lebanon Hospital
Lenox Hill Hospital
Lincoln Hospital
Lutheran Hospital of Manhattan
Manhattan Eye, Ear and Throat Hospital
Memorial Hospital for the Treatment of Cancer and Allied Diseases
Metropolitan Hospital
Midtown Hospital
Misericordia Hospital
Montefiore Hospital
Morrisania City Hospital
Mount Sinai Hospital
Neurological Institute of New York
New York Cancer Institute Hospital
New York City Hospital
New York Eye and Ear Infirmary
New York Foundling Hospital
New York Homeopathic Medical College and Flower Hospital
New York Hospital
New York Infirmary for Women and Children
New York Nursery and Child's Hospital
New York Orthopedic Dispensary and Hospital
New York Polyclinic Medical School and Hospital
New York Post-Graduate Medical School and Hospital
Park East Hospital
Park West Hospital
*Peoples Hospital
Presbyterian Hospital in the City of New York
Riverside Hospital
Roosevelt Hospital
St. Elizabeth's Hospital
St. Francis' Hospital
St. Luke's Hospital
St. Mary's Hospital for Children
St. Vincent's Hospital of the City of New York
Sloane Hospital for Women
Stuyvesant Square Hospital
Sydenham Hospital
United States Naval Hospital
West Side Hospital and Dispensary
Willard Parker Hospital
Woman's Hospital in the State of New York

NIAGARA FALLS
*Mt. St. Mary's Hospital
*Niagara Falls Memorial Hospital

NORTHPORT, L. I.
Veterans' Administration Hospital

NORWICH
Chenango Memorial Hospital

OLEAN
Olean General Hospital

ONEIDA
Broad Street Hospital

ONEONTA
Aurelia Osborn Fox Memorial Hospital

OSSINING-ON-HUDSON
Ossining Hospital
Sing Sing Prison Hospital

OTISVILLE
Municipal Sanatorium

PENN YAN
Soldiers and Sailors Memorial Hospital

PLATTSBURGH
*Champlain Valley Hospital
Physicians Hospital of Plattsburgh

PORT CHESTER
United Hospital

PORT JEFFERSON
John T. Mather Memorial Hospital

PORT JERVIS
*St. Francis Hospital

POUGHKEEPSIE
St. Francis Hospital
Vassar Brothers Hospital

RAY BROOK
New York State Hospital

RICHMOND HILL
Jamaica Hospital

ROCHESTER
Genesee Hospital
Highland Hospital
*Monroe County Hospital
Park Avenue Hospital
Rochester General Hospital
Rochester Municipal Hospital
St. Mary's Hospital
Strong Memorial Hospital

ROCKAWAY BEACH
Rockaway Beach Hospital

ROME
Rome Hospital and Murphy Memorial Hospital

SARANAC LAKE
National Variety Artists Sanatorium

SARATOGA SPRINGS
Saratoga Hospital

SCHENECTADY
Ellis Hospital

SOUTHAMPTON
Southampton Hospital

STAPLETON, S. I.
United States Marine Hospital

SUFFERN
Good Samaritan Hospital

SUNMOUNT
Veterans' Administration Hospital

SYRACUSE
Crouse-Irving Hospital
General Hospital of Syracuse
St. Joseph Hospital
Syracuse Memorial Hospital
University Hospital of the Good Shepherd

TARRYTOWN
Tarrytown Hospital

TICONDEROGA
Moses-Ludington Hospital

TOMPKINSVILLE, S. I.
Staten Island Hospital

TROY
Leonard Hospital
Samaritan Hospital
Troy Hospital

*Provisionally approved.

TRUDEAU
Trudeau Sanatorium
UTICA
Faxton Hospital
*Masonic Soldiers and Sailors Memorial Hospital
St. Elizabeth Hospital
St. Luke's Home and Hospital
Utica General Hospital
*Utica Memorial Hospital
VALHALLA
Grasslands Hospital
WARSAW
Wyoming County Community Hospital
WATERTOWN
House of the Good Samaritan
Mercy Hospital
WAVERLY
Tioga County General Hospital
WEST HAVERSTRAW
New York State Reconstruction Home
WEST NEW BRIGHTON, S. I.
St. Vincent's Hospital
Sea View Hospital
WHITE PLAINS
*St. Agnes Hospital
White Plains Hospital
YONKERS
St. John's Riverside Hospital
St. Joseph's Hospital
Yonkers General Hospital

North Carolina

ALBEMARLE
*Yadkin Hospital
ASHEVILLE
Asheville Mission Hospital
*Aston Park Hospital
Biltmore Hospital
CHARLOTTE
Charlotte Eye, Ear and Throat Hospital
Mercy Hospital
New Charlotte Sanatorium
Presbyterian Hospital
St. Peter's Hospital
DURHAM
Duke Hospital
Lincoln Hospital
Watts Hospital
FAYETTEVILLE
Highsmith Hospital
*Pittman Hospital
GASTONIA
*City Hospital
North Carolina Orthopedic Hospital
GOLDSBORO
Goldsboro Hospital
GREENSBORO
Clinic Hospital
L. Richardson Memorial Hospital
St. Leo's Hospital
Sternberger Children's Hospital
Wesley Long Hospital
GREENVILLE
*Pitt Community Hospital
HENDERSON
Maria Parham Hospital
HICKORY
Richard Baker Hospital
HIGH POINT
Burrus Memorial Hospital
KINSTON
Memorial General Hospital
*Parrott Memorial Hospital
LEAKSVILLE
*Leaksville Hospital
LENOIR
Caldwell Hospital
LINCOLNTON
Lincoln Hospital
LUMBERTON
*Baker Sanatorium
*Thompson Memorial Hospital
MT. AIRY
Martin Memorial Hospital
NORTH WILKESBORO
*Wilkes Hospital
OTEEN
Veterans' Administration Hospital
PINEHURST
Moore County Hospital
RALIEGH
Rex Hospital
St. Agnes Hospital
*State Hospital at Raleigh
ROCKY MOUNT
Atlantic Coast Line Railroad Hospital
Park View Hospital
RUTHERFORDTON
Rutherford Hospital
SALISBURY
Rowan General Hospital
SHELBY
Shelby Hospital
STATESVILLE
Davis Hospital
H. F. Long Hospital
TARBORO
Edgecombe General Hospital
TRYON
*St. Luke's Hospital
WASHINGTON
Tayloe Hospital
WAYNESVILLE
*Haywood County Hospital
WILMINGTON
Bulluck Hospital
James Walker Memorial Hospital
WILSON
Moore-Herring Hospital
WINSTON-SALEM
City Memorial Hospital
North Carolina Baptist Hospital
WRIGHTSVILLE SOUND
*Babies' Hospital

North Dakota

BISMARCK
Bismarck Hospital and Deaconess Home
St. Alexius Hospital
DEVILS LAKE
Devils Lake General Hospital
Mercy Hospital
DICKINSON
St. Joseph's Hospital
FARGO
St. John's Hospital
St. Luke's Hospital
Veterans' Administration Hospital
GRAFTON
*Grafton Deaconess Hospital
GRAND FORKS
Grand Forks Deaconess Hospital
St. Michael's Hospital
JAMESTOWN
North Dakota State Hospital for Insane
MINOT
St. Joseph's Hospital
Trinity Hospital
RUGBY
*Good Samaritan Hospital
VALLEY CITY
Mercy Hospital
WILLISTON
*Good Samaritan Hospital
*Mercy Hospital

Ohio

AKRON
Children's Hospital
City Hospital of Akron
Peoples Hospital
St. Thomas Hospital
ALLIANCE
Alliance City Hospital
BELLAIRE
City Hospital
BEREA
*Community Hospital
CANTON
Aultman Hospital
Mercy Hospital
CHILLICOTHE
Veterans' Administration Hospital
CINCINNATI
Bethesda Hospital
Children's Hospital
Christ Hospital
Christian R. Holmes Hospital
Cincinnati General Hospital
Deaconess Hospital
Good Samaritan Hospital
Hamilton County Tuberculosis Sanatorium
Jewish Hospital
St. Mary Hospital
CIRCLEVILLE
*Berger Municipal Hospital
CLEVELAND
Charity Hospital
City Hospital
Cleveland Clinic Hospital
Evangelical Deaconess Hospital
Fairview Park Hospital
Glenville Hospital
Grace Hospital
Huron Road Hospital
Lutheran Hospital
Mount Sinai Hospital of Cleveland
Polyclinic Hospital
St. Alexis Hospital
St. Ann's Maternity Hospital
St. John's Hospital of Cleveland
St. Luke's Hospital
United States Marine Hospital
University Hospitals of Cleveland:
Babies and Childrens Hospital
Lakeside Hospital
Maternity Hospital
Rainbow Hospital
Woman's Hospital
COLUMBUS
Children's Hospital
Grant Hospital
Hawkes Hospital of Mt. Carmel
Mercy Hospital
St. Ann's Infant Asylum and Maternity Hospital
St. Francis Hospital
Starling-Loving University Hospital
White Cross Hospital
DAYTON
Miami Valley Hospital
St. Elizabeth Hospital
Veterans' Administration Hospital
DOVER
Union Hospital
EAST AKRON
Springfield Lake Sanatorium
EAST LIVERPOOL
East Liverpool City Hospital
ELYRIA
Elyria Memorial Hospital and Gates Hospital for Crippled Children
FINDLAY
*Home and Hospital of the City of Findlay
FREMONT
*Memorial Hospital of Sandusky County
GALLIPOLIS
Holzer Hospital
HAMILTON
*Fort Hamilton Hospital
Mercy Hospital
LAKEWOOD
Lakewood City Hospital
LIMA
Lima Memorial Hospital
St. Rita's Hospital
LORAIN
St. Joseph's Hospital
MANSFIELD
Mansfield General Hospital
MARION
Sawyer Sanatorium
MARTINS FERRY
Martins Ferry Hospital
MASSILLON
Massillon City Hospital
MIDDLETOWN
Middletown Hospital
NEWARK
Newark Hospital
OBERLIN
Allen Hospital
PIQUA
Memorial Hospital
PORTSMOUTH
Mercy Hospital
Portsmouth General Hospital
Schirrman Hospital
SALEM
Salem City Hospital
SANDUSKY
Good Samaritan Hospital
Providence Hospital
SIDNEY
Wilson Memorial Hospital
SPRINGFIELD
City Hospital
STEUBENVILLE
Ohio Valley Hospital
TOLEDO
Flower Hospital
Lucas County Hospital
Mercy Hospital
Robinwood Hospital
St. Vincent's Hospital
Toledo Hospital
Women's and Children's Hospital
TROY
*Stouder Memorial Hospital
WARREN
St. Joseph's Riverside Hospital
Warren City Hospital
WAUSEON
De Ette Harrison Detwiler Memorial Hospital
YOUNGSTOWN
St. Elizabeth's Hospital
Youngstown Hospital
ZANESVILLE
Bethesda Hospital
Good Samaritan Hospital

Oklahoma

ARDMORE
Hardy Sanitarium
BARTLESVILLE
Washington County Memorial Hospital
CLAREMORE
Claremore Indian Hospital
CLINTON
Clinton Hospital
EL RENO
El Reno Sanitarium
LAWTON
Kiowa Indian Hospital
McALESTER
Albert Pike Hospital
MUSKOGEE
Veterans' Administration Hospital
OKLAHOMA CITY
Oklahoma City General Hospital
Reconstruction Hospital and McBride Clinic
St. Anthony's Hospital
University Hospitals
University Hospital
Crippled Children's Hospital
Wesley Hospital

PAWNEE
Pawnee-Ponca Hospital
PICHER
American Hospital
PONCA CITY
Ponca City Hospital
SHAWNEE
A. C. H. Hospital
Shawnee Indian Sanatorium
Shawnee Municipal Hospital
SULPHUR
*Soldiers' Tubercular Sanatorium
TULSA
Morningside Hospital
St. John's Hospital

Oregon

ASTORIA
Columbia Hospital
St. Mary's Hospital
BAKER
*St. Elizabeth's Hospital
CORVALLIS
Corvallis General Hospital
EUGENE
Eugene Hospital and Clinic
Pacific Hospital
KLAMATH FALLS
*Hillside Hospital
*Klamath Valley Hospital
MEDFORD
Sacred Heart Hospital
ONTARIO
Holy Rosary Hospital
OREGON CITY
Oregon City Hospital
PENDLETON
St. Anthony's Hospital
PORTLAND
Dr. Robert C. Coffey Clinic and Hospital
Doernbecher Memorial Hospital for Children
Emanuel Hospital
Good Samaritan Hospital
Multnomah Hospital
Portland Medical Hospital
Portland Sanitarium and Hospital
St. Vincent's Hospital
Shriners' Hospital for Crippled Children
Veterans' Administration Hospital
SALEM
Salem General Hospital

Pennsylvania

ABINGTON
Abington Memorial Hospital
ALLENTOWN
Allentown Hospital
Sacred Heart Hospital
ALTOONA
Altoona Hospital
Mercy Hospital
ASHLAND
*Ashland State Hospital
ASPINWALL
Veterans' Administration Hospital
BEAVER FALLS
Providence Hospital
BELLEVUE
Suburban General Hospital
BETHLEHEM
St. Luke's Hospital
BLOOMSBURG
*Bloomsburg Hospital
BLOSSBURG
Blossburg State Hospital
BRADDOCK
Braddock General Hospital
BRADFORD
Bradford Hospital
BROWNSVILLE
Brownsville General Hospital
BRYN MAWR
Bryn Mawr Hospital
CANONSBURG
Canonsburg General Hospital
CARBONDALE
*St. Joseph's Hospital
CARLISLE
Carlisle Hospital
CHAMBERSBURG
*Chambersburg Hospital
CHESTER
Chester Hospital
J. Lewis Crozer Home for Incurables and Homeopathic Hospital
CLEARFIELD
Clearfield Hospital
COALDALE
*Coaldale State Hospital
COATESVILLE
Coatesville Hospital
Veterans' Administration Hospital
COLUMBIA
*Columbia Hospital
CONNELLSVILLE
Connellsville State Hospital
DANVILLE
George F. Geisinger Memorial Hospital
DARBY
Fitzgerald Mercy Hospital
DREXEL HILL
Delaware County Hospital
DU BOIS
Du Bois Hospital
Maple Avenue Hospital
EASTON
Easton Hospital
ELIZABETHTOWN
State Hospital for Crippled Children
ERIE
Hamot Hospital
St. Vincent's Hospital
GETTYSBURG
Annie M. Warner Hospital
GREENSBURG
Westmoreland Hospital
HANOVER
Hanover General Hospital
HARRISBURG
Harrisburg Hospital
Harrisburg Polyclinic Hospital
HAZLETON
Hazleton State Hospital
HOMESTEAD
Homestead Hospital
HUNTINGDON
J. C. Blair Memorial Hospital
INDIANA
Indiana Hospital
JOHNSTOWN
Conemaugh Valley Memorial Hospital
Lee Homeopathic Hospital
Mercy Hospital of Johnstown
KANE
Community Hospital
KINGSTON
Nesbitt Memorial Hospital
LANCASTER
Lancaster General Hospital
St. Joseph's Hospital
LATROBE
*Latrobe Hospital
LEAGUE ISLAND
United States Naval Hospital
LEBANON
Good Samaritan Hospital
LEWISTOWN
Lewistown Hospital
LOCK HAVEN
*Lock Haven Hospital
MAYVIEW
*Pittsburgh City Home and Hospitals
MCKEESPORT
McKeesport Hospital
MCKEES ROCKS
Ohio Valley General Hospital
MEADVILLE
Spencer Hospital
NANTICOKE
Nanticoke State Hospital
NEW BRIGHTON
Beaver Valley General Hospital
NEW CASTLE
Jameson Memorial Hospital
New Castle Hospital
NEW EAGLE
Memorial Hospital of Monongahela
NEW KENSINGTON
Citizens General Hospital
NORRISTOWN
Montgomery Hospital
*Riverview Hospital
OIL CITY
Oil City General Hospital
PALMERTON
Palmerton Hospital
PHILADELPHIA
American Hospital for Diseases of the Stomach
American Oncologic Hospital
Broad Street Hospital
Chestnut Hill Hospital
Children's Hospital of Philadelphia
Children's Hospital of the Mary J. Drexel Home
Frankford Hospital
Garretson Hospital of Temple University
Germantown Dispensary and Hospital
Graduate Hospital of the University of Pennsylvania
Hahnemann Medical College Hospital
Hospital Lankenau
Hospital of the Protestant Episcopal Church in Philadelphia
Hospital of the University of Pennsylvania
Hospital of the Woman's Medical College of Pennsylvania
Jeanes Hospital
Jefferson Hospital
Jewish Hospital
Joseph Price Memorial Hospital
Kensington Hospital for Women
Memorial Hospital
Mercy Hospital
Methodist Episcopal Hospital
Misericordia Hospital
Mount Sinai Hospital
Northeastern Hospital of Philadelphia
Northern Liberties Hospital
Northwestern General Hospital
Pennsylvania Hospital
Philadelphia General Hospital
Philadelphia Orthopaedic Hospital and Infirmary for Nervous Diseases
Presbyterian Hospital in Philadelphia
St. Agnes Hospital
St. Christopher's Hospital for Children
St. Joseph's Hospital
St. Luke's and Children's Hospitals
St. Mary's Hospital
St. Vincent's Hospital for Women and Children
Shriners' Hospital for Crippled Children
Stetson Hospital
Temple University Hospital
Wills Hospital
Woman's Hospital of Philadelphia
Women's Homeopathic Hospital of Philadelphia
PHILIPSBURG
Philipsburg State Hospital
PITTSBURGH
Allegheny General Hospital
Children's Hospital of Pittsburgh
Elizabeth Steel Magee Hospital
Eye and Ear Hospital
Homeopathic Medical and Surgical Hospital and Dispensary
Mercy Hospital
Montefiore Hospital Association of Western Pennsylvania
Passavant Hospital
Pittsburgh Hospital
Presbyterian Hospital
Roselia Foundling Asylum and Maternity Hospital
St. Francis Hospital
St. John's General Hospital of Allegheny City
St. Joseph's Hospital and Dispensary
St. Margaret Memorial Hospital
South Side Hospital
Tuberculosis League Hospital
United States Marine Hospital
Western Pennsylvania Hospital
PITTSTON
Pittston Hospital
POTTSTOWN
*Homeopathic Hospital of Pottstown
*Pottstown Hospital
POTTSVILLE
*Lemos B. Warne Hospital
Pottsville Hospital
QUAKERTOWN
*Quakertown Community Hospital
READING
Homeopathic Medical and Surgical Hospital
Reading Hospital
St. Joseph's Hospital
RIDLEY PARK
*Taylor Hospital
ROCHESTER
Rochester General Hospital
SAYRE
Robert Packer Hospital
SCRANTON
Hahnemann Hospital
Mercy Hospital
Moses Taylor Hospital
St. Joseph's Children's and Maternity Hospital
Scranton State Hospital
SELLERSVILLE
Grand View Hospital
SEWICKLEY
Valley Hospital
SHAMOKIN
Shamokin State Hospital
SHARON
Christian H. Buhl Hospital
SHENANDOAH
*Locust Mountain State Hospital
TARENTUM
*Allegheny Valley Hospital
UNIONTOWN
Uniontown Hospital
WARREN
*Warren General Hospital
WASHINGTON
Washington Hospital
WAYNESBORO
*Waynesboro Hospital
WEST CHESTER
Chester County Hospital
Homeopathic Hospital of Chester County
WILKES-BARRE
Mercy Hospital
Wilkes-Barre General Hospital
*Wyoming Valley Homeopathic Hospital

WILKINSBURG
Columbia Hospital
WILLIAMSPORT
Williamsport Hospital
WINDBER
Windber Hospital
YORK
West Side Sanitarium
York Hospital

Rhode Island

HOWARD
State Infirmary
NEWPORT
Newport Hospital
United States Naval Hospital
PAWTUCKET
Memorial Hospital
PROVIDENCE
Charles V. Chapin Hospital
Homeopathic Hospital of Rhode Island
Miriam Hospital
Providence Lying-in Hospital
Rhode Island Hospital
St. Joseph's Hospital
WESTERLY
Westerly Hospital
WOONSOCKET
*Woonsocket Hospital

South Carolina

ANDERSON
Anderson County Hospital
BENNETTSVILLE
Marlboro County General Hospital
CHARLESTON
Baker Sanatorium
Roper Hospital
St. Francis Xavier Infirmary
United States Naval Hospital
COLUMBIA
Columbia Hospital of Richland County
South Carolina Baptist Hospital
Veterans' Administration Hospital
FLORENCE
McLeod Infirmary
*Saunders Memorial Hospital
GREENVILLE
Greenville City Hospital
*St. Francis Hospital
Shriners' Hospital for Crippled Children
ORANGEBURG
Orangeburg Hospital
PARRIS ISLAND
United States Naval Hospital
SPARTANBURG
Mary Black Clinic and Private Hospital
Spartanburg General Hospital
SUMTER
Tuomey Hospital

South Dakota

ABERDEEN
*Aberdeen Good Samaritan Hospital
St. Luke's Hospital
CHAMBERLAIN
*Chamberlain Sanitarium and Hospital
DEADWOOD
St. Joseph's Hospital
HOT SPRINGS
Veterans' Administration Hospital
HURON
Sprague Hospital
LEAD
Homestake Hospital
MADISON
Madison Community Hospital
MITCHELL
Methodist State Hospital
St. Joseph's Hospital
PIERRE
St. Mary's Hospital
RAPID CITY
Black Hills Methodist Hospital
St. John's McNamara Hospital
ROSEBUD
*Rosebud Agency Indian Hospital
SIOUX FALLS
McKennan Hospital
*Moe Hospital
Sioux Valley Hospital
WATERTOWN
Bartron Hospital
Luther Hospital
WEBSTER
Peabody Hospital
YANKTON
Sacred Heart Hospital

Tennessee

BOLIVAR
Western State Hospital
CHATTANOOGA
Baroness Erlanger Hospital
Children's Hospital
Newell and Newell Sanitarium
Pine Breeze Sanitarium
DYERSBURG
Baird-Brewer General Hospital
GREENEVILLE
Greeneville Sanatorium and Hospital
Takoma Hospital and Sanitarium
JACKSON
*Crook Sanatorium
*Memorial Hospital
JOHNSON CITY
Appalachian Hospital
Veterans' Administration Hospital
KNOXVILLE
Fort Sanders Hospital
Knoxville General Hospital
St. Mary's Memorial Hospital
MADISON
Madison Rural Sanitarium
MEMPHIS
Baptist Memorial Hospital
Gartly-Ramsay Hospital
Hospital for Crippled Adults
Memphis Eye, Ear, Nose, and Throat Hospital
Memphis General Hospital
Methodist Hospital
St. Joseph's Hospital
United States Marine Hospital
Veterans' Administration Hospital
Willis C. Campbell Clinic Hospital
MURFREESBORO
Rutherford Hospital
NASHVILLE
Barr Infirmary
George W. Hubbard Hospital
Millie E. Hale Hospital
Nashville General Hospital
Protestant Hospital
St. Thomas Hospital
Vanderbilt University Hospital

Texas

ABILENE
West Texas Baptist Sanitarium
AMARILLO
Northwest Texas Hospital
St. Anthony's Sanitarium
AUSTIN
Seton Infirmary
BEAUMONT
Beaumont General Hospital
Hotel Dieu
BIG SPRINGS
Bivings Hospital
BROWNWOOD
Medical Arts Hospital
CORPUS CHRISTI
Fred Roberts Memorial Hospital
Spohn Sanitarium
CUERO
Burns Hospital
DALLAS
Baylor University Hospital
Bradford Memorial Hospital for Babies
Dallas Medical and Surgical Clinic Hospital
Dallas Methodist Hospital
Parkland Hospital
Rushing Clinic and Sanitarium
St. Paul's Hospital
Texas Scottish Rite Hospital for Crippled Children
DENISON
*Missouri, Kansas and Texas Railroad Employes' Hospital
EL PASO
*El Paso City-County Hospital
El Paso Masonic Hospital
Hotel Dieu Sisters' Hospital
William Beaumont General Hospital
FORT SAM HOUSTON
Station Hospital
FORT WORTH
All Saints' Hospital
*Baptist Hospital of Fort Worth
*City and County Hospital
Harris Clinic-Hospital
Methodist Hospital of Fort Worth
St. Joseph's Infirmary
W. I. Cook Memorial Hospital
GALVESTON
John Sealy Hospital
St. Mary's Infirmary
United States Marine Hospital
HILLSBORO
*Boyd Sanitarium
HOUSTON
Hermann Hospital
Jefferson Davis Hospital
Memorial Hospital
Methodist Hospital
St. Joseph's Infirmary
Southern Pacific Hospital
JACKSONVILLE
Nan Travis Hospital
LAREDO
Mercy Hospital
LEGION
Veterans' Administration Hospital
LUBBOCK
*Lubbock Sanitarium
*West Texas Hospital
MARLIN
Torbett Sanatorium and Clinic
MARSHALL
Texas and Pacific Railway Employes' Hospital
MCKINNEY
McKinney City Hospital
MINERAL WELLS
Nazareth Hospital
ORANGE
*Frances Ann Lutcher Hospital
PALESTINE
International and Great Northern Railway Employes' Hospital
PARIS
St. Joseph's Infirmary
Sanitarium of Paris
PORT ARTHUR
St. Mary's Hospital, Gates Memorial
PRAIRIE VIEW
*Prairie View Hospital
SAN ANGELO
*St. John's Hospital
*Shannon West Texas Memorial Hospital
SAN ANTONIO
Medical and Surgical Hospital
Nix Hospital
Robert B. Green Memorial Hospital
Santa Rosa Hospital
SANTA ANA
Sealy Hospital
SHERMAN
St. Vincent's Sanitarium
*Wilson N. Jones Hospital
SLATON
*Mercy Hospital
TEMPLE
Gulf, Colorado and Santa Fe Hospital
King's Daughters' Hospital
Scott and White Hospital
TEXARKANA
Texarkana Hospital
WACO
Central Texas Baptist Sanitarium
Colgin Hospital and Clinic
Providence Sanitarium
Veterans' Administration Hospital
WAXAHACHIE
Waxahachie Sanitarium
WICHITA FALLS
Wichita Falls Clinic-Hospital
Wichita General Hospital

Utah

LOGAN
William Budge Memorial Hospital
OGDEN
Thomas D. Dee Memorial Hospital
SALT LAKE CITY
Dr. W. H. Groves Latter Day Saints Hospital
Holy Cross Hospital
St. Mark's Hospital
Salt Lake General Hospital
Veterans' Administration Hospital

Vermont

BARRE
Barre City Hospital
BRATTLEBORO
Brattleboro Memorial Hospital
BURLINGTON
Bishop de Goesbriand Hospital
Mary Fletcher Hospital
MIDDLEBURY
Porter Hospital
MONTPELIER
Heaton Hospital
RUTLAND
Rutland Hospital
ST. ALBANS
*St. Albans Hospital
ST. JOHNSBURY
*Brightlook Hospital
WINOOSKI
Fanny Allen Hospital

Virginia

ABINGDON
George Ben Johnston Memorial Hospital
CHARLOTTESVILLE
*Martha Jefferson Hospital
CLIFTON FORGE
Chesapeake and Ohio Hospital
COLONY
*State Colony for Epileptics and Feeble-minded
DANVILLE
*Memorial Hospital
FARMVILLE
Southside Community Hospital

HAMPTON
Dixie Hospital
Veterans' Administration Hospital
LYNCHBURG
Lynchburg Hospital
Marshall Lodge Memorial Hospital
Virginia Baptist Hospital
NEWPORT NEWS
Elizabeth Buxton Hospital
Riverside Hospital
NORFOLK
Hospital of St. Vincent de Paul
Memorial Hospital of Norfolk
Norfolk Protestant Hospital
Sarah Leigh Hospital
United States Marine Hospital
PETERSBURG
Medical Center-Central State Hospital
Petersburg Hospital
PORTSMOUTH
King's Daughters' Hospital
Parrish Memorial Hospital
United States Naval Hospital
PULASKI
*Pulaski Hospital
RICHMOND
Crippled Children's Hospital
*Grace Hospital
Johnston-Willis Hospital
Medical College of Virginia, the Memorial, the Dooley and St. Philip Hospitals
Retreat for the Sick
St. Elizabeth's Hospital
St. Luke's Hospital
Sheltering Arms Hospital
Stuart Circle Hospital
Tucker Sanatorium
ROANOKE
*Burrell Memorial Hospital
Gill Memorial Eye, Ear, and Throat Hospital
Jefferson Hospital
Lewis-Gale Hospital
Roanoke Hospital
Shenandoah Hospital
STAUNTON
King's Daughters' Hospital
SUFFOLK
Lakeview Hospital
UNIVERSITY
University of Virginia Hospital
WINCHESTER
Winchester Memorial Hospital

Washington

ABERDEEN
Aberdeen General Hospital
St. Joseph's Hospital
AMERICAN LAKE
Veterans' Administration Hospital
BELLINGHAM
St. Joseph's Hospital
Saint Lake's General Hospital
BREMERTON, PUGET SOUND
United States Naval Hospital
COLFAX
*St. Ignatius Hospital
ELLENSBURG
Ellensburg General Hospital
EVERETT
General Hospital of Everett
Providence Hospital
OLYMPIA
St. Peter's Hospital
PASCO
Our Lady of Lourdes Hospital
PORT ANGELES
Port Angeles Hospital and Sanitarium
RICHMOND HIGHLANDS
Firland Sanatorium
SEATTLE
Children's Orthopedic Hospital
Columbus Hospital
Harborview Hospital
Maynard Hospital
Providence Hospital
St. Luke's Hospital
Seattle General Hospital
Swedish Hospital
United States Marine Hospital
Virginia Mason Hospital
SHELTON
*Shelton General Hospital
SPOKANE
Deaconess Hospital
Sacred Heart Hospital
St. Luke's Hospital
Shriners' Hospital for Crippled Children—Mobile Unit
TACOMA
Northern Pacific Beneficial Association Hospital
Pierce County Hospital
St. Joseph's Hospital
Tacoma General Hospital
U. S. Tacoma Hospital
VANCOUVER
Clark General Hospital
St. Joseph's Hospital
WALLA WALLA
St. Mary's Hospital
Veterans' Administration Hospital
*Walla Walla Sanitarium and Hospital
WENATCHEE
Central Washington Deaconess Hospital
St. Anthony's Hospital
YAKIMA
St. Elizabeth's Hospital

West Virginia

BECKLEY
Beckley Hospital
Raleigh General Hospital
BLUEFIELD
Bluefield Sanitarium
St. Luke's Hospital
BUCKHANNON
*St. Joseph's Hospital
CHARLESTON
Kanawha Valley Hospital
McMillan Hospital
Mountain State Hospital
New Charleston General Hospital
*St. Francis Hospital
CLARKSBURG
Mason Hospital
St. Mary's Hospital
ELKINS
Davis Memorial Hospital
Elkins City Hospital
FAIRMONT
Cook Hospital
Fairmont Emergency Hospital
GLENDALE
Reynolds Memorial Hospital
HINTON
*Hinton Hospital
HOPEMONT
*Hopemont Sanitarium
HUNTINGTON
Chesapeake and Ohio Hospital
Huntington Memorial Hospital
St. Mary's Hospital
Veterans' Administration Hospital
LAKIN
*Lakin State Hospital
LOGAN
Hatfield-Lawson Hospital
MARTINSBURG
City Hospital
*King's Daughters' Hospital
MONTGOMERY
Coal Valley Hospital
MORGANTOWN
*Monongalia County Hospital
OAK HILL
Oak Hill Hospital
PARKERSBURG
Camden-Clark Memorial Hospital
*St. Joseph's Hospital
PRINCETON
Mercer Memorial Hospital
RONCEVERTE
Greenbrier Valley Hospital
WELCH
Grace Hospital
Stevens Clinic Hospital
Welch Emergency Hospital
WHEELING
Ohio Valley General Hospital
Wheeling Hospital
WILLIAMSON
*Williamson Memorial Hospital

Wisconsin

APPLETON
St. Elizabeth Hospital
ASHLAND
*Ashland General Hospital
St. Joseph's Hospital
BELOIT
Beloit Municipal Hospital
BURLINGTON
*Memorial Hospital
DODGEVILLE
St. Joseph's Hospital
EAU CLAIRE
Luther Hospital
FOND DU LAC
St. Agnes Hospital
GREEN BAY
Bellin Memorial Hospital
St. Mary's Hospital
JANESVILLE
Mercy Hospital
KENOSHA
Kenosha Hospital
St. Catherine's Hospital
LA CROSSE
Grandview Hospital
La Crosse Hospital
La Crosse Lutheran Hospital
St. Francis Hospital
MADISON
Madison General Hospital
Methodist Hospital
St. Mary's Hospital
State of Wisconsin General Hospital
Wisconsin Orthopedic Hospital for Children
MANITOWOC
Holy Family Hospital
MARSHFIELD
St. Joseph's Hospital
MILWAUKEE
Columbia Hospital
Evangelical Deaconess Hospital
Johnston Emergency Hospital
Milwaukee Children's Hospital
Milwaukee General Hospital
Milwaukee Hospital
Misericordia Hospital
Mount Sinai Hospital
Sacred Heart Sanitarium
St. Joseph's Hospital
St. Luke's Hospital
St. Mary's Hospital
Veterans' Administration Hospital
NEENAH
Theda Clark Memorial Hospital
OSHKOSH
Mercy—St. Mary's Hospital
RACINE
St. Luke's Hospital
St. Mary's Hospital
SHEBOYGAN
*Sheboygan Memorial Hospital
STEVENS POINT
St. Michael's Hospital
SUPERIOR
St. Mary's Hospital
WAUSAU
St. Mary's Hospital
Wausau Memorial Hospital
WAUWATOSA
Milwaukee County Hospital
Muirdale Sanatorium

Wyoming

BASIN
Wyoming Tuberculosis Sanatorium
CASPER
*Memorial Hospital of Natrona County
CHEYENNE
Memorial Hospital of Laramie County
EVANSTON
Wyoming State Hospital
MIDWEST
Midwest Hospital
ROCK SPRINGS
Wyoming General Hospital
SHERIDAN
Sheridan County Memorial Hospital
Veterans' Administration Hospital
WHEATLAND
Wheatland General Hospital

Alaska

FORT YUKON
Hudson Stuck Memorial Hospital

Canal Zone

ANCON
Gorgas Hospital

Hawaii

HILO
Hilo Memorial Hospital
HONOLULU
*Japanese Hospital
Kauikeolani Children's Hospital
Leahi Home
Queen's Hospital
St. Francis Hospital
Shriners' Hospital for Crippled Children

Porto Rico

SAN JUAN
Presbyterian Hospital

CANADA

Alberta

BANFF
Banff Mineral Springs Hospital
CALGARY
Calgary General Hospital
Colonel Belcher Hospital
Holy Cross Hospital
CAMROSE
St. Mary's Hospital
DRUMHELLER
Drumheller Municipal Hospital
EDMONTON
Edmonton General Hospital
Misericordia Hospital
Royal Alexandra Hospital
University of Alberta Hospital
HANNA
*Hanna Municipal Hospital
LAMONT
Lamont Public Hospital
LETHBRIDGE
Galt Hospital
St. Michael's Hospital

MEDICINE HAT
Medicine Hat General Hospital
RED DEER
Red Deer Municipal Hospital
STETTLER
Stettler Municipal Hospital
VEGREVILLE
Vegreville General Hospital

British Columbia

CRANBROOK
*St. Eugene Hospital
ESSONDALE
Provincial Mental Hospital
KAMLOOPS
Royal Inland Hospital
KELOWNA
*Kelowna General Hospital
NEW WESTMINSTER
Royal Columbian Hospital
TRANQUILLE
Tranquille Sanatorium
VANCOUVER
Grace Hospital
St. Paul's Hospital
Shaughnessy Hospital
VICTORIA
Provincial Royal Jubilee Hospital
St. Joseph's Hospital

Manitoba

BRANDON
Brandon General Hospital
NINETTE
Manitoba Sanatorium Hospital
ST. BONIFACE
St. Boniface Hospital
ST. VITAL
St. Boniface Sanatorium
WINNIPEG
Children's Hospital of Winnipeg
Grace Hospital
Misericordia Hospital
Municipal Hospitals
King Edward Memorial Hospital
King George Hospital
St. Joseph's Hospital
Shriners' Hospital for Crippled Children—Mobile Unit
*Victoria Hospital
Winnipeg General Hospital

New Brunswick

CAMPBELLTON
Hotel Dieu Hospital
Restigouche and Bay Chaleur Soldiers' Memorial Hospital
CHATHAM
Hotel Dieu Hospital
FREDERICTON
Victoria Public Hospital
MONCTON
Hotel Dieu de l'Assomption
Moncton Hospital
NEWCASTLE
Miramichi Hospital
ST. BASIL
Hotel Dieu of St. Joseph
SAINT JOHN
Lancaster Hospital
Saint John County Hospital
Saint John General Hospital
St. Joseph's Hospital
ST. STEPHEN
Chipman Memorial Hospital
TRACADIE
Hotel Dieu of St. Joseph
WOODSTOCK
Carleton County L. P. Fisher Memorial Hospital

Nova Scotia

AMHERST
Highland View Hospital

*Provisionally approved.

ANTIGONISH
St. Martha's Hospital
GLACE BAY
Glace Bay General Hospital
St. Joseph's Hospital
HALIFAX
Camp Hill Hospital
*Children's Hospital
Grace Maternity Hospital
Halifax Infirmary
Victoria General Hospital
KENTVILLE
Nova Scotia Sanatorium
NEW GLASGOW
Aberdeen Hospital
NEW WATERFORD
New Waterford General Hospital
NORTH SYDNEY
Hamilton Memorial Hospital
SYDNEY
*St. Rita Hospital
*Sydney City Hospital
SYDNEY MINES
Harbour View Hospital
TRURO
Colchester County Hospital
YARMOUTH NORTH
*Yarmouth Hospital

Ontario

BRANTFORD
Brantford General Hospital
BROCKVILLE
*Brockville General Hospital
*St. Vincent de Paul Hospital
BYRON
Queen Alexandra Sanatorium
CHATHAM
Public General Hospital
St. Joseph's Hospital
CORNWALL
*Cornwall General Hospital
*Hotel Dieu Hospital
FORT WILLIAM
McKellar General Hospital
GALT
Galt General Hospital
GRAVENHURST
Muskoka Hospital for Consumptives
GUELPH
St. Joseph's Hospital
HAMILTON
Hamilton General Hospital
Mountain Sanatorium
St. Joseph's Hospital
KINGSTON
Hotel Dieu Hospital
Kingston General Hospital
KITCHENER
St. Mary's Hospital
LONDON
St. Joseph's Hospital
Victoria Hospital
Westminster Hospital
NIAGARA FALLS
*Niagara Falls General Hospital
OSHAWA
Oshawa General Hospital
OTTAWA
Ottawa Civic Hospital
Ottawa General Hospital
OWEN SOUND
General and Marine Hospital
PETERBORO
Nicholls Hospital
St. Joseph's Hospital
PORT ARTHUR
St. Joseph's General Hospital
ST. CATHARINES
Niagara Peninsula Sanitarium
St. Catharines General Hospital
ST. THOMAS
Memorial Hospital
SAULT STE. MARIE
General Hospital
SMITHS FALLS
*St. Francis General Hospital
*Smiths Falls Public Hospital
STRATFORD
Stratford General Hospital
SUDBURY
St. Joseph's Hospital
TORONTO
Christie Street Hospital
Grace Hospital Division of the Toronto Western Hospital
Hospital for Sick Children
Lockwood Clinic Hospital
Riverdale Isolation Hospital
St. Joseph's Hospital
St. Michael's Hospital
Toronto East General Hospital
Toronto General Hospital
Toronto Western Hospital
Wellesley Hospital
Women's College Hospital
WALKERVILLE
Metropolitan General Hospital
WELLAND
*Welland County General Hospital
WESTON
Toronto Hospital for Consumptives
WINDSOR
Hotel Dieu of St. Joseph
Salvation Army Grace Hospital
WOODSTOCK
Woodstock General Hospital
Prince Edward Island
CHARLOTTETOWN
Charlottetown Hospital
Prince Edward Island Hospital
SUMMERSIDE
Prince County Hospital

Quebec

LACHINE
*Lachine General Hospital
MONTREAL
Alexandra Hospital
Children's Memorial Hospital
Homeopathic Hospital of Montreal
Hôpital de la Misericorde and Catholic Maternity
Hôpital Sainte Jeanne D'Arc
Hôpital Sainte Justine, Pour Les Enfants
Hôpital Saint-Luc
Hotel Dieu de Saint Joseph
L'Hôpital Notre Dame
Montreal Foundling and Baby Hospital
Montreal General Hospital, Central Division
Montreal General Hospital, Western Division
Royal Victoria — Montreal Maternity Hospital
*Sacred Heart Hospital
Shriners' Hospital for Crippled Children
Woman's General Hospital
QUEBEC
Hôpital de l'Enfant Jesus
Hôpital du Saint Sacrement
Hotel Dieu du Precieux Sang
Jeffery Hale Hospital
ST. ANNE DE BELLEVUE
St. Anne de Bellevue Hospital
STE. FOY
Hôpital Laval
ST. HYACINTHE
St. Charles Hospital
SHERBROOKE
Hôpital General St. Vincent de Paul
Sherbrooke Hospital
TROIS RIVIERES
Hôpital St. Joseph

Saskatchewan

CANORA
*Hugh Waddell Memorial Hospital
FORT QU' APPELLE
Fort Qu' Appelle Sanatorium
HUMBOLDT
St. Elizabeth's Hospital
MACKLIN
*St. Joseph's Hospital
MOOSE JAW
Moose Jaw General Hospital
Providence Hospital
NORTH BATTLEFORD
Notre Dame Hospital
PRINCE ALBERT
Holy Family Hospital
Prince Albert Sanatorium
Victoria Hospital
REGINA
Regina General Hospital
Regina Grey Nuns' Hospital
SASKATOON
City Hospital
St. Paul's Hospital
Saskatoon Sanatorium
TISDALE
*St. Therese Hospital

Other Countries

Australia

NEW SOUTH WALES—Lewisham Hospital, Sydney; Newcastle Hospital, Newcastle; Royal Alexandra Hospital for Children, Camperdown, Sydney; Royal North Sydney Hospital, Sydney; Royal Prince Alfred Hospital, Camperdown, Sydney; St. Vincent's Hospital, Sydney; Sydney Hospital, Sydney.

VICTORIA — Alfred Hospital, Melbourne; Austin Hospital, Melbourne; Children's Hospital, Melbourne; Melbourne Hospital, Melbourne; Queen Victoria Memorial Hospital, Melbourne; St. Vincent's Hospital, Melbourne; Women's Hospital, Melbourne.

CHINA—Peking Union Medical College Hospital, Peking.

CUBA—Clinica Fortun-Souza, Havana; Francisco M. Fernandez Hospital, Havana; Instituto Del Cancer, Havana.

FRANCE—American Hospital, Paris.

NEWFOUNDLAND — Notre Dame Bay Memorial Hospital, Twillingate; St. Anthony Hospital, St. Anthony.

NEW ZEALAND — Auckland Hospital, Auckland; Cashmere Sanatorium, Christchurch; Christchurch Hospital, Christchurch; Dunedin Hospital, Dunedin; Wellington Hospital, Wellington.

REPUBLIC OF PANAMA—Hospital de Panama, Panama; Hospital Santo Tomas, Panama.

URUGUAY — Gynecological Hospital (Pereira Rossell), Montevideo; Maternity Hospital (Pereira Rossell), Montevideo.

Montana Sisters Form State Hospital Group

SPONSORED by Most Rev. Edwin V. O'Hara, bishop of Great Falls, an association of the Catholic Hospitals of Montana has been organized by Sisters from the Catholic hospitals throughout the state who met at Columbus Hospital, Great Falls, September 8 and 9.

The session opened with Holy Mass and an address by Bishop O'Hara, Sister M. Wilhelmina, R. N., Ph. C., B. C., acting as chairman, and Sister Emmelia, F. C. S. P., as secretary. Mother Gaudentia, superior, Columbus Hospital, greeted the visitors. After the introductory remarks by the chairman, Msgr. Victor Day, administrator of the diocese of Helena, was introduced, and urged that religious instructions be included in the curriculum for nurses. Sister M. Wilhelmina emphasized the necessity of forming a state hospital association and of joining the national hospital association.

Sister Mary William, R. N., Miles City, spoke on the "Relation of State Board Rulings to Hospital Management."

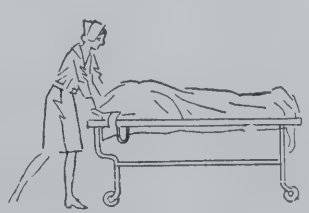
The afternoon session was opened by Rev. James Brogan, S. J., Havre, who discussed "The Ethical Reasons for the Code of Catholic Hospitals." At 2 p. m. the meeting was under the auspices of the ladies of the Hospital Guild, Mrs. O. F. Wadsworth presiding. Rev. J. A. Rooney, Butte, spoke of "The Possibility of Obtaining College Credits for Nurses Who Complete Their Training." Mrs. Warren Toole, first and former president of the Guild, explained the organization and the valuable work done by its members.

The ladies of the Guild then took the visitors to points of interest in the city. This feature was much enjoyed.

The evening session was entirely devoted to the discussion of hospital economy. Sister Magdalene of Providence, Missoula, presented a paper on "Ways and Means of Curtailing Expenses." Benediction of the Blessed Sacrament was given by Msgr. O'Day. The Saturday morning session was opened by Holy Mass by Bishop O'Hara. Visitors were conducted to the sixth floor, where the supervisors explained the workings and the management of the various departments. From here the Sisters were taken to the obstetrical department where Sister John Eucharist, supervisor, explained the technique of the birth-room as well as the nurseries.

At 9 a. m. sessions were resumed "Increased Efficiency in Hospital Collections" was presented by Sister M. Jeannette, Billings; "Why a Central Food Service" by Clara Phalan, B. S.; "Curriculum of School Nursing" by Sister Mary, B. S., Spokane, Wash.; "Contract Work in Hospitals" by Dr. J. W. Irwin, president, Columbus Hospital staff. Dr. H. J. McGregor gave a talk on "Hospitals and the N. R. A."

The afternoon session was opened by a talk on the "Advantages of a Catholic Hospital Association" by Dr. L. W. Allard, Billings. This was followed by a paper by Miriam Marks on "Why a Nurse Should Participate in Parish Activities." A paper was then presented by Sister Pascal, Lewistown, on "Problems of Small Hospital and Small Training Schools."



FAXON AT W. VA. MEETING

Dr. N. W. Faxon, Rochester, N. Y., president of the American Hospital Association, spoke before the Hospital Association of West Virginia at the annual meeting in Clarksburg October 3 at the Stonewall Jackson Hotel. The meeting was called to order by Dr. A. G. Rutherford, president, whose address was "Hospital Economics." Others on the program included Dr. H. H. Esker, Clarksburg, president of the Harrison County Medical Society; Dr. T. L. Harris, Parkersburg, vice-president of the West Virginia State Medical Association; Ruth MacMaster, Huntington, superintendent of the Huntington Memorial Hospital; Dr. R. H. Walker, Charleston, and Dr. C. R. Ogden, Clarksburg. Joe W. Savage, Charleston, is executive secretary of the association.

The new officers of the West Virginia Association are:

President—Dr. T. K. Oates, Martinsburg.

First vice-president—Dr. James McClung, Richwood.

Second vice-president—Dr. E. F. Heiskell, Morgantown.

Trustee—Dr. W. A. McMillan, Charleston.

Secretary-treasurer—Charles W. Warner, Charleston.

ROTARIANS HEAR JOLLY

Robert Jolly, superintendent, Memorial Hospital, Houston, Texas, and president-elect of the American Hospital Association, was the featured speaker at the Chicago Rotarians' luncheon, October 3. Dr. Franklin H. Martin, director general of the American College of Surgeons, was chairman of the meeting.

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Congratulations on That Wonderful Institute

HOSPITAL MANAGEMENT warmly congratulates all who had anything to do with the highly successful institute in hospital administration which the American Hospital Association and other groups sponsored at the University of Chicago. Many believe that the success of this affair means that some similar activity will be carried on annually.

The general impression of the first institute was that it was successful beyond all expectations of the most optimistic. As was to be expected, there were rough spots here and there, but these were mostly of a minor nature and were due in part to the fact that the registration was nearly 400 per cent of what had been originally expected. In this connection, the tender of its admirable facilities and trained personnel by the University of Chicago proved a life-saver, for without the physical plant for housing, feeding and for classes, the institute would have been tangled and its schedules might not have been put into operation for a week after the start. As it was, the work of registering, housing and feeding the students, and the arrangement of their class and field schedules was handled in expert fashion, even though the unexpectedly large registration, coupled with the opening of the university, called for prompt solutions of some unexpected problems in individual instances.

Many may not know that the man who was primarily responsible for the institute was Dr. M. T. MacEachern, director of hospital activities of the American College of Surgeons. For a number of years such institutes have been talked of, and the need recognized, but until Dr. MacEachern bestirred himself, consulted representatives of various groups and called a preliminary meeting to discuss the matter with a view to action, the talk and suggestions never got to the stage where a meeting for the serious discussion of a plan was called.

There are a number of lessons to be learned from this first experiment, of course. One is that the registration be limited to superintendents, assistant superintendents, or to those who have a direct interest in the general management of a hospital. If others are to be eligible, there ought to be a separate course for them, so that technical features that do not personally concern superintendents need not be discussed at the sessions attended by them.

Another lesson is that when two lectures are given at the same time, this schedule should be repeated at a later date in order that the students may attend one lecture one day and the other later. It is impossible sometimes to avoid scheduling lectures at the same time, of course.

Some comments of the students were to the effect that lecturers should be selected not only for what they know, but also for their ability to present their subjects and, of course, lecturers should study the characteristics of the work of the students in order to adapt lectures to the needs of the individuals, and not to take up time with fundamentals or with details in which a given class may have little interest.

These comments are only echoes of what was heard during the three weeks, and the suggestions and criticisms all were offered in a spirit of helpfulness and not of fault-finding. Even the most critical admitted that he or she was more than satisfied with the institute and that if there is to be another next year he or she will put forth every effort to attend.

The Recipe for a "Hospital-Minded" Community

The leading article in the last issue of HOSPITAL MANAGEMENT was a summary of a study made by Dr. MacEachern of the American College of Surgeons in regard to conditions which must be corrected before there can be a "new deal" for hospitals. Unusual attention was attracted by this study, for which no one was better qualified than Dr. MacEachern. The study was commented on editorially last month, emphasis being placed on the fact that Dr. MacEachern placed a "hospital minded" community as the first requirement for the hospitals' "new deal."

It was pointed out that many hospitals have within their power methods of making their communities "hospital minded," but that very few appreciate how easy and how extremely valuable the attainment of a "hospital minded" community really is.

The point to be made in these comments here is that the recipe for a "hospital minded" community is simple:

To have a "hospital minded" community it is only necessary to have a "community minded" hospital.

By a "community minded" hospital is meant a hospital that really appreciates the value of good will and community understanding and a hospital that actually avails itself of a number of ideas and plans for gaining public favor in an ethical, economical and convenient way.

What is the best plan for most hospitals to use to gain public good will?

HOSPITAL MANAGEMENT believes that the answer to this question is a hospital bulletin. As a matter of fact Dr. MacEachern's 1933 report as chairman of the A. H. A. Committee on publicity said that every hospital should have a monthly bulletin, mimeographed or printed.

There are so many uses for a bulletin, so many practical benefits to be gained from one that it is no wonder that this form of community contact is growing in favor among hospitals. Bulletins may be inexpensive and most convenient from the standpoint of publishing, etc., and they rightly might have been termed the basis of the educational program for any hospital.

So the hospital that is "community minded" can begin its program of winning new friends and holding old ones through a bulletin, for a bulletin is the badge of a "community minded" hospital and a most important factor in making a community "hospital minded."

One Reason Why Hospitals Want Place on A. C. S. List

One of the secrets of success of the American College of Surgeons is that it insists on rigid adherence to the spirit as well as the letter of its minimum standard. No matter how big and influential a hospital is, the question of whether the institution's name is to appear on the approved list or not is decided solely on the record that the hospital has made during the year of survey, in regard to adherence to the principles outlined in the hospital standardization program.

The College has been most lenient and most encouraging to small hospitals and it has been just as insistent on the complete compliance with the minimum standard of the larger institution which seeks approval.

The announcement in connection with the publication of the 1933 list of approved hospitals that a number of hospitals have been "demoted" from complete approval to conditional approval and that some institutions have been removed from the list as "unrated" because of failure to comply with the provisions of the minimum standard is typical of the work of the College in this matter and is in part an explanation of the success which the College has achieved in its hospital standardization.

Under such a method of procedure the appearance of a name of a hospital on an approved list means much and that is why hospitals, and particularly hospital superintendents, go to such lengths to meet the minimum standard.

Record Librarians Make Unparalleled Progress

The recent convention of the Association of Record Librarians of North America was not only by far the best and most successful in its brief history, but it was a convention that would have won commendation for an organization twice as old. The progress of the association in activity as well as membership has been made during the years that have been unmatched in financial stringency.

The organization was scarcely a year old when the financial crash came and in the ensuing four years when most associations suffered loss of membership and impairment of function, the record librarians marched onward and upward. At the recent conference it was reported that there now are 19 local chapters, six state associations and 511 members in good standing. Moreover the association has completed its plans for a national registry and already has some 250 registered record librarians. Its program for approving schools for training record librarians has reached the stage where the first "approved list" is ready.

These two accomplishments alone would stamp the record librarians' association as unusual, and the fact that they have been achieved during the past few years means that the officers and members merit all the greater praise.

Every hospital will benefit from the success of the A. R. L. N. A., for this success tends to make staff members more "record conscious," thus tending to reduce the number of incomplete and unsatisfactory records. The state of records in many hospitals has been a source of worry to superintendents and has in numerous instances prevented a hospital from getting full approval from the American College of Surgeons.

So the hospitals should rejoice in the success of the A. R. L. N. A. and should cooperate with the record librarians by encouraging their own record department workers to join the association and to take an active part in the program that ultimately has for its objects the advancement of medical knowledge and the better care of the patient.

Press Features A. C. S. Criticism of Hospitals

Recent hospital conferences of the American College of Surgeons have been marked by reports of sensational statements against hospitals by officers or members of the College. The 1933 conference was no exception. During its deliberations a Chicago newspaper published under a seven-column headline a series of charges by the director-general of the College who was quoted as asserting that hospitals made unfair charges for certain services, that they maintained expensive and unnecessary luxuries and as enumerating other sins of hospitals.

HOSPITAL MANAGEMENT believes that a close examination of Dr. Martin's remarks would disclose that he was referring only to a small percentage of institutions and merely issuing a general warning.

But the 400,000 readers of the newspaper know only what they read and the sensational way in which the unqualified criticisms were presented to these readers simply means that hospital boards and administrators have that much more public antagonism to overcome.

Everyone familiar with hospital standardization or with any similar movement in any field realizes that it costs more to give good service than it does to give haphazard service. In these times of severe economic distress it has required courage and a constant struggle on the part of many hospitals to maintain their A. C. S. rating. The annual standardization report of the College attests this and praises these hospitals for their performance.

It seems a pity that the College which originated and so successfully developed the standardization movement should at its annual conferences develop such unfavorable publicity for hospitals, especially since the College's part in this destructive publicity is wholly unintentional and innocent.

Cardinal Points in Control of Hospital Commissary

By MAGDALIN V. DIEKEN
Supervisor of Storeroom, Minneapolis General Hospital, Minneapolis, Minn.

IT has been requested that I outline some of the principles of storeroom management as they commend themselves to me from my personal experience, and I have therefore set down in the following paragraphs what I consider to be the cardinal points of commissary controls.

Just as a hospital must be equipped to give prompt and efficient service to the patients, so the commissary of a hospital must provide an ever-ready source of supplies. The commissary is constantly faced not only with the problem of maintaining the medical and surgical equipment of the hospital in perfect condition and the issue of a continuous stream of medical and surgical supplies, but it must at the same time promptly meet the needs of the dietetic department, looking to the feeding of both personnel and patients and bearing in mind the particular requirements of the special diet kitchen. If the working people are the backbone of a nation, then certainly the commissary of a hospital may be said to bear that same relation to a hospital. It is the center wherein all hospital activities find beginning and end, for both sustenance and shrouds are secured from the storeroom.

The foundation of efficient commissary management is that of any successful business enterprise, namely, the establishment of systematic controls. In a storeroom these controls or records must show at a glance the supplies of every kind on hand. A most accurate check must be kept of all articles in order to keep up this supply. I believe that a Kardex system most ably affords such a check system. A Kardex system should be installed for this purpose. A card should be kept for each item in the storeroom, with the name of this article printed on so that it can be easily read. This card should also carry the information showing from whom the article was purchased, price of same, and the date as well as the amount received in each delivery of purchases. Similarly whenever a delivery is made from the stock in compliance with a hospital requisition, it should be immediately deducted from the last total on the card maintained for that particular article. In this manner a perpetual inventory of the entire storeroom stock is maintained. At the Minneapolis General Hospital we use a card like that here shown. (Exhibit I.)

In addition to or supplementing the card just referred to, a daily record should be kept of all merchandise received in the storeroom, using a separate page for each day's receipts. The column headings of such a page are presented in Exhibit II. This may be either a loose leaf or a bound volume at the discretion of the individual institution. In the Minneapolis General Hospital we use the loose-leaf system because of the fact that with the great volume of supplies handled, a large bound book adequate for the year's needs would be very heavy and unwieldy. The loose leaves can be transferred to another binder at fixed intervals of six months, three months, or at the close of each month if desired. In those hospitals which have a receiving clerk separate from the storeroom, this daily record book would be kept in the receiving clerk's office. Under such circumstances a carbon copy of each completed page would have to be sent to the office of the commissary supervisor.

Besides keeping systematic records in the storeroom, it is also essential that the ordering of supplies from the storeroom and the disbursement of such supplies should likewise be definitely systematized. If this is not done, intense confusion must inevitably result. At the Minneapolis General Hospital, an order book is supplied to all stations and departments which carries a list of the various articles used, and columns for pricing. (Exhibit III.) This listing enables the head nurse on each station to check her dressing room and supply rooms and lessens emergency orders upon the storeroom by lessening possibilities of forgetting to order articles needed. The books should be sent to the superintendent's office on requisition days and there checked and initialed by the superintendent or the assistant superintendent, and then forwarded to the storeroom. In most institutions the requisition books from nursing stations are checked by the superintendent of nurses or one of her assistants before going to the office of the superintendent of the hospital, or the nursing office and administrative office may check them together. In the storeroom the articles are checked in the book as the orders are filled and as each order is complete the white sheet (perforated) is torn out, and the yellow sheet (unperforated)

Exhibit I, card giving information regarding source of supply, price, quantity received and quantity requisitioned.

It's YOUR *wife,* DOCTOR!

NRA MEMBER U.S. WE DO OUR PART

Anxiety runs high when the life or health of a loved one is at stake. And when surgery becomes necessary only one consideration is paramount—safety—the best surgical skill available—and the safest anesthetic.

Many surgeons and anesthetists who require a pure, safe ether depend upon Squibb's. For three-quarters of a century Squibb Ether has been carrying patients safely through the unconscious and post-operative periods with a minimum of danger. It is the only ether packaged in copper-lined containers to prevent formation of oxidation by-products. It offers, in addition, the protection of a mechanical closure to avoid solder contamination. This mechanical closure is so designed that a safety pin may be inserted for use as a dropper to administer the Ether by the Open-Drop Method.

When surgery becomes necessary choose that ether which long and wide experience has proved to be a pure, safe and effective ether for surgical use. Choose Squibb's—the world's standard anesthetic ether.

For further information about Squibb Ether mail the coupon below

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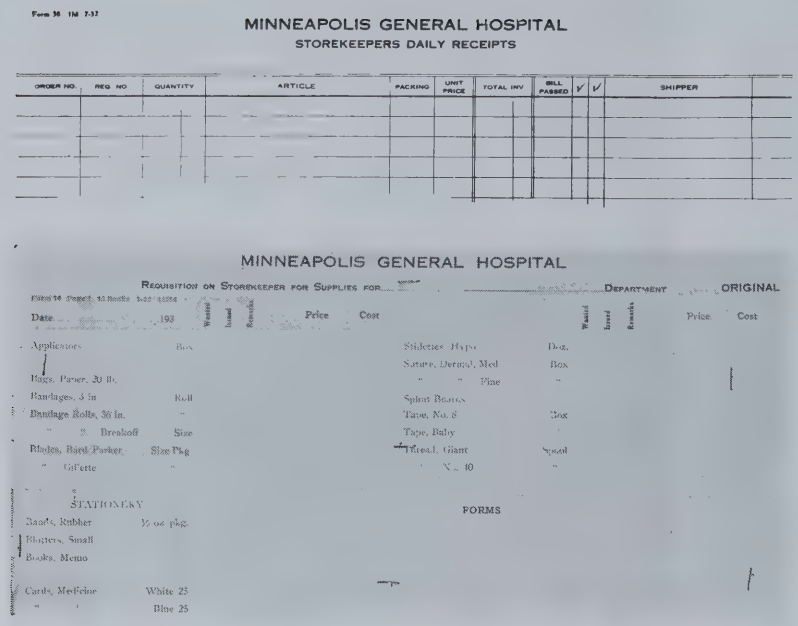
E. R. Squibb & Sons, *Anesthetic Department,*
6610 Squibb Building, New York City

Please send me a copy of your booklet on Open Ether Anesthesia ☐. I would also like a copy of your booklet on Spinal Anesthesia ☐. Ether-Oil Squibb ☐.

Name .....

Street .....

City ..... *State* .....



MINNEAPOLIS GENERAL HOSPITAL
STOREKEEPERS DAILY RECEIPTS

ORDER NO.	REQ. NO	QUANTITY	ARTICLE	PACKING	UNIT PRICE	TOTAL INV	BILL PASSED	✓	✓	SHIPPER

MINNEAPOLIS GENERAL HOSPITAL

REQUISITION ON STOREKEEPER FOR SUPPLIES FOR ..... DEPARTMENT ..... ORIGINAL

Date 193

		Wanted	Issued	Remarks	Price	Cost
Applicators	Box					
Bags, Paper, 30 lb.						
Bandages, 3 in	Roll					
Bandage Rolls, 36 in.	"					
" 2 Breakoff	Size					
Blades, Bard Parker	Size Pkg					
" Gillette	"					
STATIONERY						
Bands, Rubber	½ oz pkg.					
Blotters, Small						
Books, Memo						
Cards, MedFeine	White 25					
" "	Blue 25					

		Wanted	Issued	Remarks	Price	Cost
Stilettes Hypo	Doz.					
Suture, Dermal, Med	Box					
" Fine	"					
Splint Beaves						
Tape, No. 8	Box					
Tape, Baby	"					
Thread, Giant	Spool					
" No. 40	"					
FORMS						

Above is shown form recording each day's receipts of merchandise by store room (Exhibit II), and below is an excerpt from the order book supplied to all stations at Minneapolis General Hospital (Exhibit III).

showing a carbon copy of the order returns to the station in the book with the supplies.

We would suggest that a certain day each week be designated for the delivery of merchandise to the various hospital departments. At the Minneapolis General Hospital we have designated Monday as our day for receiving these requisitions, as this enables the departments to start the week with full equipment. If the supply should run out before the week is over, an emergency order is made out, but the departments are not allowed to make a practice of this except in extreme emergencies, as there is no reason why they cannot estimate their wants in advance.

It would be impossible of course to limit the kitchens to one order per week as they would require too large a storage space and groceries would lose their flavor and strength if exposed so long. These orders should be submitted daily and delivered to the kitchens 24 hours before they are to be used.

The stock in the storeroom should be so systematized that it becomes an easy matter to fill these requisitions and to deliver all orders the first of the week. The stationery, for example, should all be placed on shelves in numerical (form number) sequence and all requisitions should be ordered by form number instead of by name. It would be a very difficult matter to remember the names of 300 different forms and where each is stored so as to fill orders speedily. All other stationery should be located in the same general section. Cleaning materials should all be kept together. All medical and surgical supplies should be kept in one section. The same principle holds good for groceries. All canned goods should be placed on the shelves and attractively displayed.

If any equipment is destroyed during the week, the broken pieces should be returned to the storeroom in company with the replacement requisition. These requisitions should be turned in at the same time as the weekly requisitions for new supplies so that both orders may be filled at the same time and one delivery suffice for the two. In this way an accurate cost accounting can be kept on all breakage and a comparative statement of condemned goods and an adjustment be made before the cost becomes too extreme.

When Monday is set aside as the day for the receipt of requisitions from the various hospital departments, it is possible by Tuesday afternoon to have all orders filled, the stock and shelves put back in order, and to have the balance of the week conserved for the clerical work of the commissary. This is important. Each item on every order must be posted on the Kardex system and priced thereon. The orders must then be posted to a ledger. By adherence to a system such as has been outlined in the foregoing paragraphs, it is possible to arrive at the departmental cost as well as the total cost of merchandise handled by the storeroom each month.

Offers Family Hospitalization

(*Continued from page 25*)

15. Fifty per cent off for pollen machine in unusual cases of asthma or acute hay fever.

16. Fifty per cent reduction on use of oxygen tent, when needed.

17. Fifty per cent reduction on all room charges.

Coverage without time limit applies to the wife and each dependent minor member of the family in case of accident, sickness, and operation, subject to the following exceptions: This family group hospitalization plan does not apply to tubercular, mental, venereal, contagious or quarantinable diseases. Except in acute emergencies, it does not apply to chronic conditions until coverage is in effect for three months. It does not include your physician's bill nor the services of special private nurses. Benefits in maternity cases apply only after ten months' membership.

The usual proportion of the ordinary hospital bill absorbed by this plan is about two-thirds, including all uncertain items like operating room and anesthetic charges, drugs, etc., which are so hard to foretell. Baylor is not trying to make a profit but to play safe for both hospital and patients for the benefit of all. It is believed that at the present time no more liberal or more helpful plan has yet been devised for families.

This Family Group Plan does not take the place of nor affect the Group Hospitalization Plan already in force; it is an added service and benefit offered through our present groups.

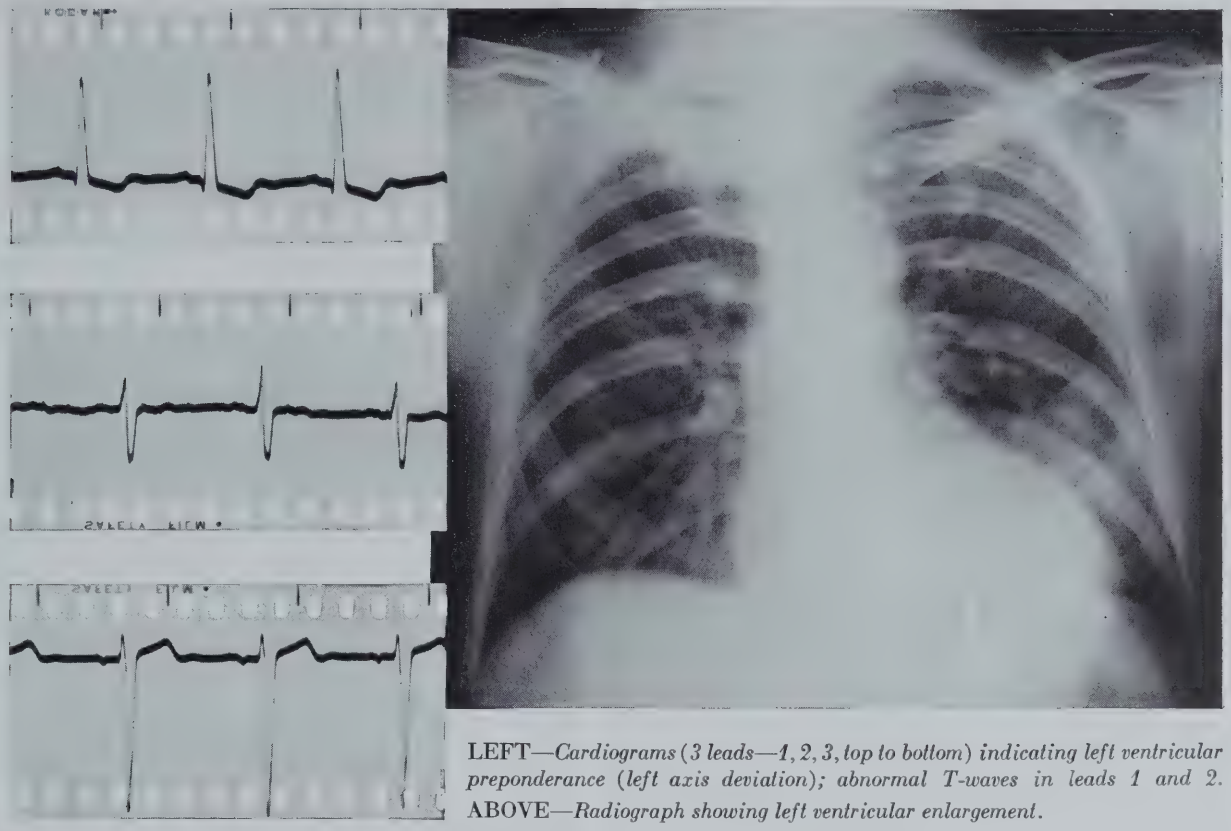
"An illustration of the working of the Family Group Plan:

"Mrs. John Doe enters the hospital for an abdominal operation and leaves after 10 days' stay. Under the usual plan her hospital bill other than room accommodations would run about as follows:

Operating room	$17.00
Anesthetic	12.00
Laboratory tests	3.00
Drugs	5.00
Surgical dressings	7.50
Miscellaneous items	10.00
	$54.50
Room accommodations: from $30.00 to	$100.00
Total bill: Runs from $84.50 to	$154.50

"The above six items, totalling $54.50 will be absorbed by the Family Group Plan; in addition, the Family Group Plan would absorb one-half the cost of her room accommodations during her stay. These room accommodations vary from $3 to $10 per day, selection being made by the patient; so the patient would pay for the 10 days' stay a sum varying from $15 to $50, according to the room accommodation she chose."

THE RADIOGRAPH for Pathology



LEFT—*Cardiograms (3 leads—1, 2, 3, top to bottom) indicating left ventricular preponderance (left axis deviation); abnormal T-waves in leads 1 and 2.*
ABOVE—*Radiograph showing left ventricular enlargement.*

THE CARDIOGRAM for Function

THESE two examinations—the radiographic and the cardiographic—provide the comprehensive information that is necessary to arrive at a definite diagnosis in the study of heart conditions.

With these two types of graphic records, the cardiologist can study the disorders which reflect themselves in characteristic changes in the heart's size, shape, and position . . . can take into account arrhythmias, disorders of myocardial function, and prognosis.

For Radiography there is Eastman Ultra-Speed X-ray Film which provides maximum sensitivity and contrast. Even with the long anode-film distance necessary for correctly recording the heart's size, shape, and position, the minimum exposure time can be used.

For Electrocardiography Eastman Cardiographic Film and P. M. C. Bromide Paper No. 1 provide those photographic properties that assure accurate tracings . . . the exact recording of every impulse. The cardiograms have unusual contrast. Exposed areas are densely black. Unexposed areas remain absolutely clear. Eastman Kodak Company, *Medical Division*, Rochester, New York.

Eastman

Ultra-Speed X-ray Film, Cardiographic Film and Paper

What Do You Mean, "Laundry Costs?"

By HUGH F. DENNETT
Laundry Management Engineer, Wauwatosa, Wis.

COST figures have sometimes been referred to as signposts on the road of good management. Whether they and they alone point out the road is perhaps open to argument, but they offer material aid in the efficient management of almost any enterprise. None can appreciate the truth of this better than those who are compelled to rely upon cold figures for the administration of an organization when conditions necessitate that most of the administrative problems be left to a subordinate.

Cost figures are not a stranger to most of us and they do have a very definite and very important message if they have been designed to furnish us with that message. They can be full of interest and importance or they can be equally cold and forbidding, and, in not a few cases, unimportant. That laundry of yours is just one department in your hospital, but the matter of salaries, supplies and other expenses represent no small item in your annual operating statement.

When we first consider the matter of operating costs there may seem to be quite a wide difference between an institutional laundry plant and the commercial laundry. Actually, however, the two plants have a great deal in common and the same fundamental system of cost records are adaptable for both.

The following list of accounts will serve to show just what expenses enter into a picture of operating costs in a commercial laundry and those which are not marked with asterisk (*) are just as applicable to the hospital laundry as they are to the commercial plant:

1. Productive labor.
2. Soap and soda.
3. Other washroom supplies.
4. Starch.
5. General supplies.
6. Paper and twine.
7. Boxes, boards and bands.*
8. Aprons, coverings, pads.
9. Water softener supplies.
10. Water.
11. Machine repairs and maintenance.
12. Machine depreciation.
13. Insurance on equipment.
14. Taxes.*
15. Building repairs and maintenance.
16. Building depreciation.
17. Fire insurance.
18. Rent.
19. Light.
20. Taxes on building.*
21. Indirect labor.
22. Superintendence.
23. Liability insurance.
24. Miscellaneous indirect expense.
25. Indirect supplies.
26. Engineer's time.
27. Fuel used.
28. Electric power.
29. Power plant supplies.
30. Drivers' wages.*
31. Agents' commissions.*
32. Sundry agency expense.*
33. Branch office expense.*
34. Truck licenses.*
35. Truck insurance.*
36. Truck depreciation.*
37. Truck repairs.*
38. Tires and tubes.*
39. Gas, oil.*
40. Truck miscellaneous.*
41. Executive salaries.*
42. Office salaries.*
43. Bad debt apportionment.*
44. Office expense.*
45. Stationery and printing.
46. Lost and damaged goods.
47. Free work.*
48. Audit and legal.*
49. Donations.*
50. Dues and subscriptions.*
51. Financing charges.*

These accounts have been set up by the Laundryowners' National Association for the guidance and convenience of member plants. They take into consideration every factor that can properly be charged in as a cost of doing laundry work, but since they were designed and set up primarily for the commercial laundry they must be revised to some extent in order to be applicable to the hospital laundry. Accounts numbers 14 and 20 need not be considered in the average hospital laundry, as well as accounts 30 to 40 inclusive, 40 to 44 inclusive, and accounts 47 to 51 inclusive.

There are very few hospital laundries in which provision has been made for measuring the amount of water, steam and purchased power, and while a part of the total charges for these items should be charged against the laundry department we generally find that the work involved in obtaining these costs is all out of proportion to the value derived from the figures. Practically all of the other accounts are self-explanatory with the exception of number 1, which should include only those operators in the plant who are actually engaged in processing work; number 3, which would include the items of bleach, sour (neutralizer), nets and blue; and account number 21, which takes care of janitor services. Some of the accounts representing such items as janitor service, and so forth, must be prorated, and the most logical basis for this prorating seems to be on the basis of floor space occupied by the department.

The matter of prorating the hospital laundry superintendent's salary presents a little different problem. It is customary in commercial laundries to prorate a superintendent's salary between the superintendence account and the productive labor account on the basis of the estimated time that he spends in each capacity. The average hospital laundry, however, is administered by a working superintendent who spends the great majority of his time in doing productive work and because of this fact I suggest that his salary be divided in the following manner: Charge as much of his salary to productive labor as you would have to pay to a full time operator in that position and charge the difference between this amount and his actual salary to superintendence. For instance, if your superintendent spends most of his time washing, charge against the productive labor account an amount equal to that which you would have to pay somebody else to do the washing and then charge the difference between this amount and his actual salary to account number 22.

While it is not uncommon to find these various costs expressed in so many dollars or cents a hundred pounds in commercial laundries, the most common system, by far, is to express them as a percentage of the weekly volume of business. This method is impracticable, of course, for us since we have no weekly volume of sales and as a consequence we have little choice but to adopt the poundage basis when expressing our costs. Even the patient-day basis is unsuitable for expressing laundry costs when we are considering the laundry only.

Now, it is one thing to set up a cost system for ourselves, it is important and should be done—but if we can compare our costs with the other fellow who is operating under the same conditions we have increased the value of our cost data tremendously. A comparison of costs in this way brings to mind the almost unbelievable spread that exists in some of these items in plants operating under the same conditions.

Before you can compare costs

(*Continued on page 53*)

"New deal" for patients opens up new source of income

Mt. Sinai Hospital, New York City—completely equipped with Day's Curtain Screening

A RECENT editorial in "Modern Hospital" significantly remarks—

"—The private hospital, except in cases of medical or surgical emergency, must collect a fee from ward patients if it is to survive. The public is gradually learning that it must pay at least a moderate fee for hospital care.—"

Many hospitals have found that Day's Curtain Screening provides that *plus value* which induces patients to willingly pay a small fee for ward service that includes the privacy and convenience of this modern bed-side screening.

Patients like Day's Curtain Screening. And nurses like it, too. It's so clean, quick and convenient. With the curtains back against the wall, the rooms are nice and light and airy. No trouble to enclose an entire bed with one curtain. Nothing to lug around. Nothing to obstruct the movements of nurses and doctors.

Wouldn't you like to have this modern system of bed-side screening in *your* hospital? Over 350 installations in the country's leading hospitals automatically recommend this equipment to you. Equally suited for new building construction and for modernization programs.

Our Engineering Department will gladly make a careful study of your particular needs and submit recommendations that will assure you of outstanding advantages at a price comparable with any other screening.

Want complete information? Just mail the coupon for our interesting and helpful booklet "Privacy in the Modern Hospital."

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Founded 1817

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H. L. JUDD COMPANY, INC.,
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I'd like to have a copy of "Privacy in the Modern Hospital"—which shows how leading hospitals have modernized their facilities with suitable bedside screening.

Your Name.....

Hospital .....

Address .....H.M. 10-33

DAY'S CUBICLE CURTAIN EQUIPMENT

How Much Money Are You Wasting on Nourishment Service?

Survey by Methodist Hospital, Indianapolis, Which Reduced Expense of In-between Meals 35% Offers Suggestion to Other Institutions

By VERNA ANSORGE

Assistant Dietitian, Methodist Hospital, Indianapolis, Ind.

SPECIAL attention to the serving of nourishments or in-between meals to patients in the Methodist Hospital, Indianapolis, began to receive unusual consideration during the early part of the year. It became necessary here as elsewhere, in view of the existing economic situation, to reduce unnecessary expenditures to a minimum, so that the hospital might meet its obligations and yet render the same type of efficient service as had been the custom previously. To accomplish this, a survey was recommended by the hospital statistician. The fact was established and well known to the hospital officials and dietary department that the serving of nourishments should be curbed and in this way a substantial decrease in the expenditure for food realized.

A study of the situation revealed that nourishments were being served in many other than therapeutic instances. In the past nourishments began to take on the character of solid meals; such foods as meat and cheese sandwiches, whole fruits and desserts were ordered. To overcome this tendency, nourishments were emphatically limited to beverages and ice cream only. The order sheet was made up in the following manner:

Broths—
- Beef
- Chicken
- Beef juice
- Bouillon cubes

Albumens—
- Orange
- Lemon
- Grape

Malted Milk—
- Plain
- Chocolate
- Egg

Gruels—
- Barley
- Oatmeal
- Cream of Wheat

Fruit Ades—
- Orange
- Lemon
- Grape

Miscellaneous—
- Ice cream
- Eggnog
- Cocoa
- Milk
- Buttermilk

It had been the custom for the diet nurse to order nourishments under the supervision of the floor supervisor. An explanation and purpose of the survey was given to both supervisors and students and cooperation was anticipated from both. Disadvantages observed by serving nourishments were varied. The serving required the entire time of one floor nurse from one-half to one hour and the serving pantries were frequently left in an untidy condition which did not in any manner facilitate the next meal service. It was found that on many occasions the student nurse assigned to the serving of nourishments was occupied with the care of patients and was not in the serving unit to pass nourishments when they were received. Consequently, the patient received his beverage or ice cream very late, within a short time of his next meal.

It was advised that nourishments be served only where they were necessary as a therapeutic measure, or when especially requested or when ordered by the physician. Observation also showed that with the taking of an in-between feeding, the following meal was often only partially eaten, which in turn added to the garbage accumulation.

Recipes for the preparation of various beverages were standardized and these beverages were made and sent from a central dispensary. The use of four ounce glasses was instituted, thus producing an effective reduction in quantity. Supplies were never kept in the floor refrigerators except in rare cases.

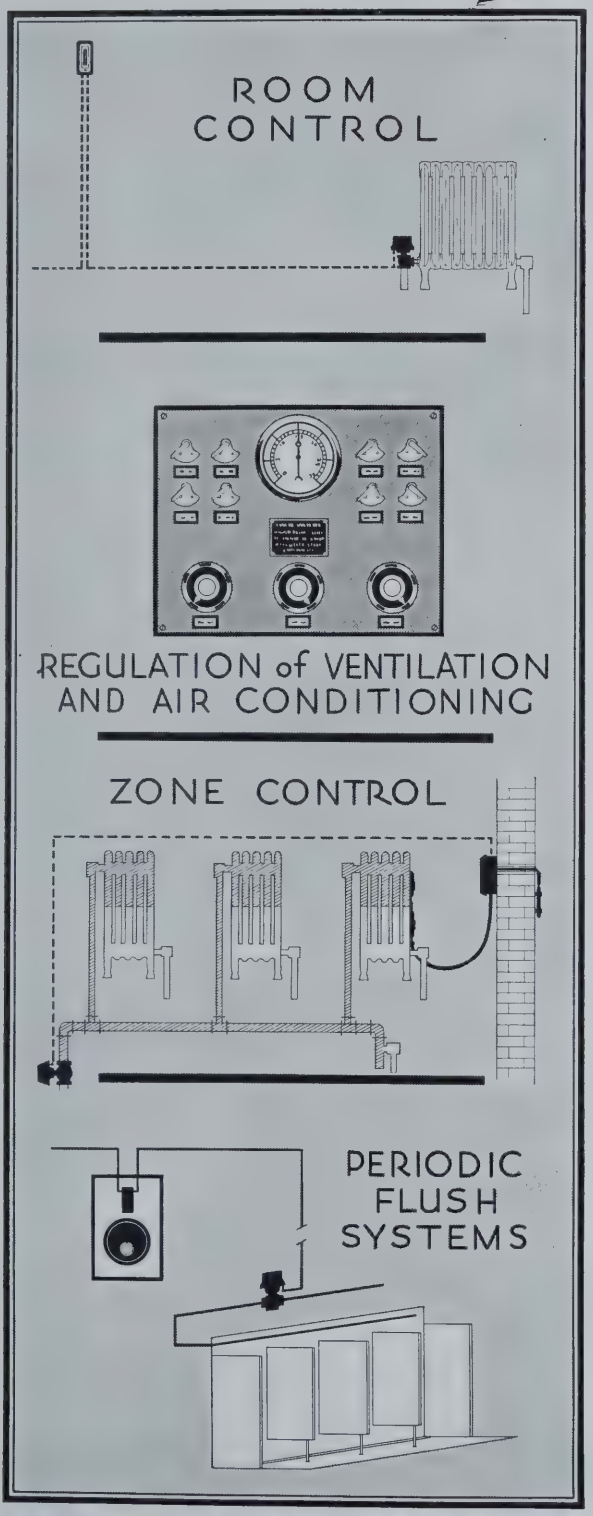
The dietitian assigned to the survey made daily notes which included every floor service and issued a typewritten statement to each supervisor respectively. The cost of the service for each floor was calculated separately for both morning and afternoon. This also was brought to the attention of the floor head in com-

July 1. 3:30—Excess orders. Three servings orangeade over.
July 2. 3:30—Late in serving.
July 3. 3:30—O. K.
July 4. 3:30—O. K.
July 5. 3:30—Nourishments not in refrigerator.
July 6. 3:30—O. K.
July 7. 3:30—Excess of ice cream, two servings.
July 8. 3:30—Orange juice not used.
N. B.—Your floor spent .... per cent of entire expenditure for nourishments for the month.

"The dietitian assigned to the survey made daily notes which included every floor service and issued a typewritten statement to each supervisor."

Modernize for Economy!

NRA MEMBER U.S. WE DO OUR PART



JOHNSON

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THOROUGHLY MODERN, yet based on nearly half a century of experience in design, manufacture, and installation, *Johnson apparatus* is available for a variety of applications. It plays an important part in the modernization of the mechanical plant in any type of building.

To control ROOM TEMPERATURES, *Johnson thermostats* operate simple, rugged radiator valves or mixing dampers. Room thermostats may be had in the single temperature pattern or with the well-known *Johnson "Dual"* arrangement, providing a reduced, economy temperature when certain sections of the building are unoccupied. . . . For VENTILATION AND AIR CONDITIONING plants, there are thermostats, humidostats, and switches to control valves and dampers, start and stop motors on temperature and humidity variation. Heating, cooling, humidifying, dehumidifying—whatever the problem, *Johnson equipment* is the answer . . .

JOHNSON ZONE CONTROL has been developed to a fine point. Groups of radiators are controlled by the *Johnson "Duo-Stat"* in accordance with the proper relationship between outdoor and radiator temperatures. . . . JOHNSON PERIODIC FLUSH SYSTEMS are simple, dependable, utilizing the full force of the water supply for cleansing, and reducing the load on supply and waste pipes by intermittent flushing in various parts of the building . . .

ECONOMY is the direct dividend paid by *Johnson installations.* Comfort and convenience are the inevitable by-products. . . . Sales engineers located at thirty branch offices in the United States and Canada will survey and report on *your* requirements, without obligation, just as they have done in the case of countless buildings and groups of buildings all over the continent.

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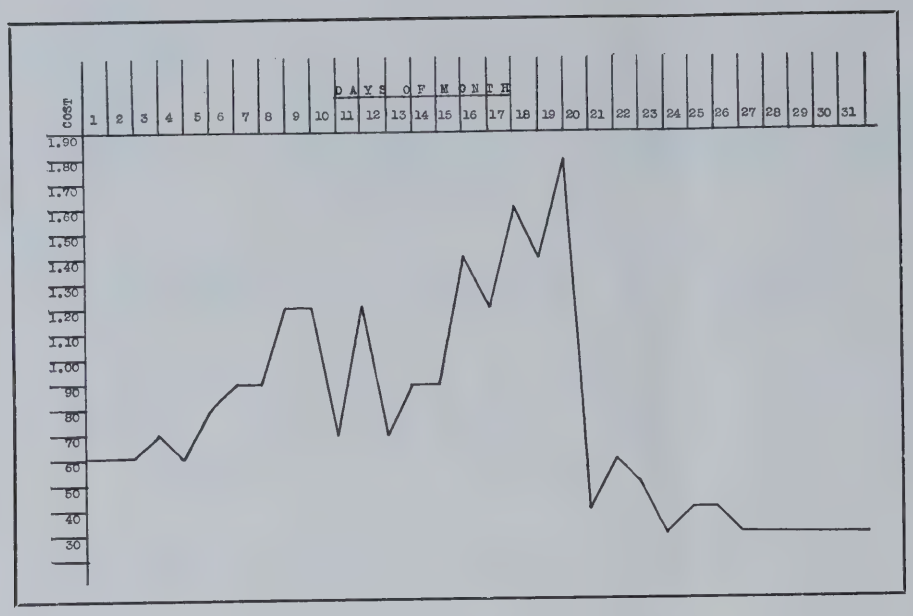

parative relation to other floor expenditures. Further cooperation was requested.

It may be definitely stated that the ability to quote actual figures proved to be an important method in impressing the importance of this measure upon the individual and gaining his cooperation. Former expenditures for nourishments per month reached the sums of $205 to $218. After counting costs for one month only, the expense was brought to $136, or reduced approximately 35 to 40 per cent. Further reduction is anticipated.

How losses in nourishment service were reduced as result of program described in this article.

Minneapolis General Hospital Details Dietary Activity in Report

MINNEAPOLIS General Hospital, Dr. Charles E. Remy, superintendent, recently compiled an unusually detailed report of its activities for a year, and the report of the food service department, which is given in considerable detail in this article, is typical of the thoroughness with which the entire study was made. The hospital report requires three mimeographed volumes and covers 234 pages. One volume is devoted to the superintendent's didactic and statistical report, another to technical administrative divisions, and the third with professional care of patients.

"Whereas it may ordinarily be considered more convenient to receive a report in one volume," writes Dr. Remy in the foreword, "we believe that this may be compensated for to some extent by the greater feasibility of the distribution of the parts of the report to the various divisions of the hospitals receiving it. The superintendent may be interested in all portions of a hospital report. On the other hand, the chiefs of staff are only interested in that portion of a report having to do with the professional care of patients and will seldom bother to look through a report if it be handed to them in toto. We acknowledge that we are deviating from established hospital custom and will be glad to receive comments from persons who receive the report."

The report is for the year 1931, with a comparison with a previous year. In introducing the figures regarding the dietetic department, Ethel I. Gough, dietitian, says:

"The year of 1931 has been rather eventful for the dietary department. The total cost of operating this department is only $1,215.10 or about 1 per cent greater than for 1930, while the number of meals served to the staff and patients has increased 68,568 or 8 per cent. At the beginning of the year the dining room in the annex was discontinued and those people are being served in the dining rooms in the main building. A waitress was added to take care of this increase, otherwise the number of employes in this department remains the same. I might say here that the maids who served in the annex dining room were under the supervision of the School of Nursing.

"We have added two new pieces of equipment, namely, the Savory toaster and the U. S. bread slicing machine. Two small terrazzo table tops are being tried out in the employes' dining room. If they prove satisfactory, it is the plan to replace all of the large tables with the smaller. In both the nurses' and doctors' dining rooms, racks for napkins have been placed. Two more tables have been added in the interns' dining room. A bright figured cretonne material has been purchased for curtains in the nurses' and doctors' dining rooms.

"The number of meals served from the special diet kitchen has increased about 4.6 per cent. A change of service from this kitchen has been made. Instead of each tray being served directly from the special diet kitchen, an Ideal food conveyor carries the food to the station kitchens and the special trays are put out from there.

"In July we increased the number of students taking the post graduate course in dietetics from two to four. The student dietitians' rooms were moved from single rooms on second and third floors of the annex to two adjoining rooms on the first floor annex."

There have been some material changes in costs of foodstuffs and other items since 1931, the period of the report, but nevertheless the figures showing the expense and activity of the dietary department are of

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THERE'S something almost hypnotic about this new Adobe china. On its mellow, soothing surface the most depressing diet is transformed into what seems a jovial feast. It isn't exactly magic that makes this change. It's rather a true appreciation for the beauty which Nature herself has given foods. Plus the one color—Adobe—which more than any other seems to "package" Nature's own color tones in the most appealing appetizing manner.

One of the most satisfying experiences you can have today is to sit at the bedside of a weary, discouraged patient who is having his food served for the first time on an Adobe service. They sit up just a bit straighter as soon as they spy the tray. Unfold the napkin as if they meant business. Start to eat as if it were a banquet in their honor. Don't stop until the last morsel disappears. And these are people who the meal before, may have grumbled, pushed away their food.

We know that today's budgets are not very flexible. But we also know that no hospital can afford not to at least see this new Adobe Ware—and we include physicians as well as dietitians.

Hospital after hospital have proved repeatedly that Syracuse China—and that means Adobe—can establish new records in low breakage, minimum in replacements. It is vitrified, specially treated to resist chipping and cracking. The color pattern cannot fade or become scratched—because it is *under* a rugged though invisible surface glaze.

See Adobe Ware—now—at your nearest supply dealer. There is one in every principal city. If you cannot locate him readily write our Syracuse office. You should not miss this opportunity to win the everlasting appreciation of every patient under your care.

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Graceful Shapes
Perfect blend of color and contour in a sugar and creamer—that will delight your patients.

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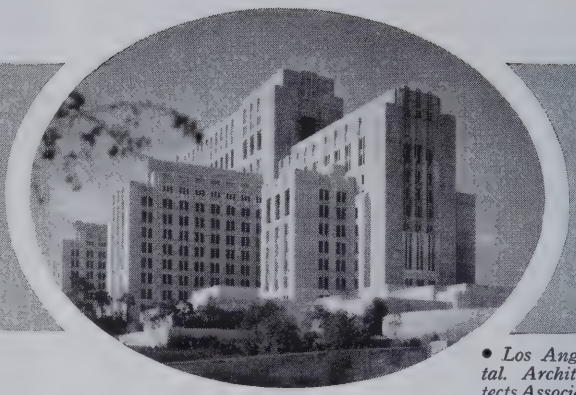
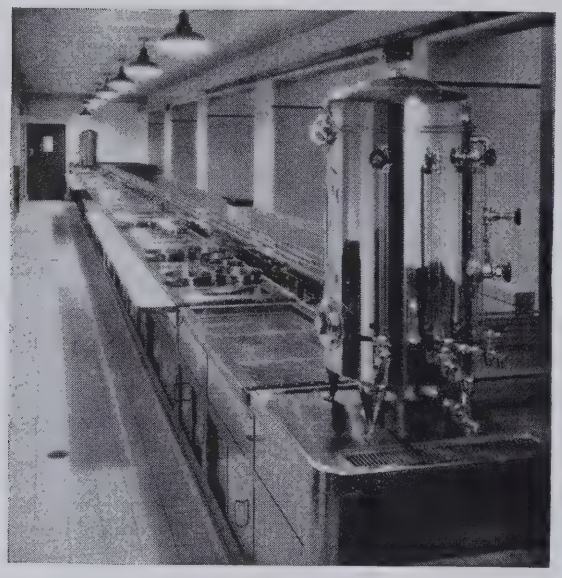
7 Cafeterias.....
8 Diet Kitchens....
100 Food Trucks....



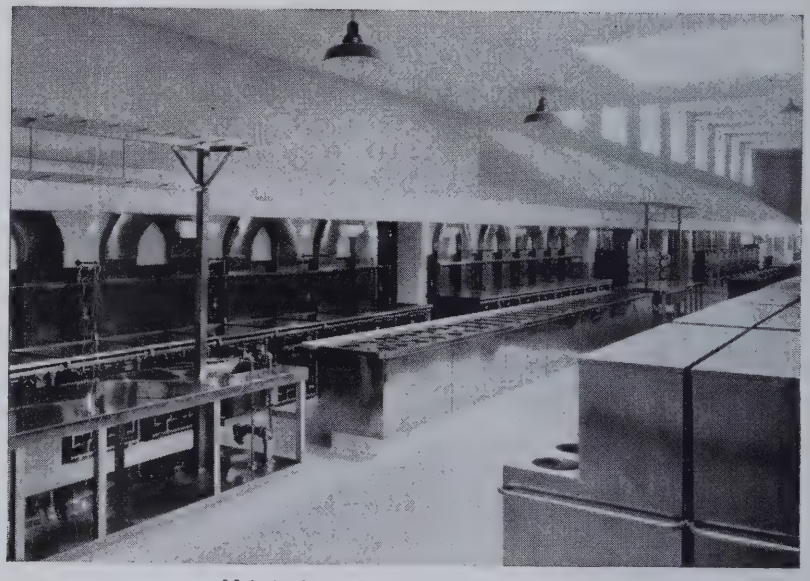
• *Los Angeles County Hospital. Architects: Allied Architects Association of Los Angeles.*

—ONLY *PART* OF THE MONEL METAL EQUIPMENT

in World's Largest County Hospital!



• *Nurses' Main Cafeteria, Los Angeles County Hospital. Food service installation of Monel Metal by National Cornice Works of Los Angeles.*



• *Main kitchen in Los Angeles County Hospital. Monel Metal food service equipment installed by National Cornice Works of Los Angeles.*

● The Los Angeles County Hospital is not only the largest county hospital in the world, but one of the most cheerful, efficient and modern, too... and Monel Metal has helped to make it so.

For this hospital has gone in for Monel Metal in a big way. Besides the 7 cafeterias and 8 diet kitchens, The National Cornice Works of Los Angeles has also equipped the huge main kitchen with Monel Metal. The Monel Metal desk and counter tops were made by the General Fireproofing Company of Youngstown, O. And besides the 100 food trucks, J. L. Davidson Company, Inc. of Los Angeles also supplied a battery of Monel Metal ice cream cabinets... and even mortuary trucks made of Monel Metal.

The shining beauty of this silvery Nickel alloy is as easy to keep clean as it looks. Monel Metal is absolutely rust-proof and stoutly resists corrosion.

Monel Metal, stronger than steel, will give a lifetime of service. It is solid metal right through... no coating to chip, crack or wear off. Monel Metal equipment stands the gaff of hospital use as no other equipment can.

Write and ask us about Monel Metal's performance in other hospitals... not only in food service departments, but in clinical and laundry use as well.

• • •

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interest. They are of particular interest to those connected with larger hospitals and those who present annual or other reports in considerable detail.

Some of the special features of this departmental report, as compared with the average report, are the showing of the cost of meal served officers and personnel, cost of meals served patients on house diet, and cost of special diets served. Other unusual details presented are dish breakage, value of food and dishes supplied direct by storeroom to stations, milk report, gas consumption, etc.

Because of the great detail into which the report goes, which is characteristic of the report for the entire institution, the figures of the dietary department are shown, even those that cover the year 1931.

FOOD COSTS

	1930	1931
Food—kitchen	$74,283.17	$74,335.10
Food—direct to stations	13,575.68	13,665.51
Food—cash	29.00	35.00
Labor	20,914.05	21,364.52
Gas	1,294.66	1,119.19
Linen—condemned	198.13	241.76
Drugs	42.40	61.80
Dishes	590.27	882.36
Supplies, new	409.73	325.52
Cleaning materials	540.56	606.43
Stationery	47.47	64.43
Supplies, condemned	51.36	258.81
Equipment, new		485.64
Repairs and equipment	533.20	276.30
Miscellaneous	3.99	6.40
	$112,513.67	$113,728.77
No. of meals served	853,951	922,518
Average cost per cooked meal per person	$.1317	$.1232
Average cost per uncooked meal per person	.1029	.0956

MAIN KITCHEN—STAFF

Food	$45,063.40	$43,664.37
Labor and gas	16,517.74*	16,669.19
Miscellaneous		1,147.75
Dishes		483.87
Repairs		138.17
New equipment		485.64
	$61,581.14	$62,588.99
Meals—		
Officers and interns	58,690	65,410
Nurses	181,404	208,651
Employes	124,235	122,293
Night force	15,985	16,729
Contagious bldg.	26,404	
Total number of meals served.	406,718	413,090
Average cost per cooked meal per person	$.151	$.1515
Average cost per uncooked meal per person	.110	.1056

DIET KITCHEN—PATIENTS

Food	$36,478.64	$34,441.76
Labor and gas*	3,893.20	3,899.99
Miscellaneous		50.65
Dishes		26.14
Repairs		138.13
	$40,371.84	$40,556.67
Total number of patients' meals served	405,722	450,753
Average cost per cooked meal per person	$.099	$.0899
Average cost per uncooked meal per person	.089	.0808

SPECIAL DIET KITCHEN

Food—cash	$ 31.00	$ 35.00
Food	7,052.61	7,972.91
Labor and gas*	1,689.95	1,720.62
Dishes		372.35
Miscellaneous		366.75
	$8,773.56	$10,467.63
Total meals	41,511	58,675
Average cost per cooked meal	$.211	$.1784
Average cost per uncooked meal	$.176	$.1364

*During 1930 only two accounts were kept, one for food and one for labor, gas, *and other supplies.*

VALUES OF FOOD AND DISHES

Supplied by the storeroom direct to the stations.

	Food 1930	Food 1931
Station A	$ 171.65	$ 1,263.66
Station B	1,411.21	1,134.62
Station C	1,629.95	1,578.41
Station D	2,078.82	1,900.90
Station E	1,869.91	1,650.85
Station F	1,586.15	1,589.09
Pediatrics I. & J.	3,030.62	2,552.74
Isolation	707.81	789.71
Contagion	1,089.56	1,205.53
	$13,575.68	$13,665.51

	Dishes 1930	Dishes 1931
Station A	$ 34.06	$ 84.24
Station B	46.63	38.04
Station C	46.48	24.26
Station D	114.43	104.64
Station E	105.83	80.39
Station F	99.37	76.76
Pediatrics I. & J.	45.24	11.85
Isolation	18.70	32.06
Contagion	44.51	60.31
	$555.25	$512.55

DISH BREAKAGE

	1930	1931
Cups	107	109
Cereal bowls	42	62
Butter plates	116	122
Glasses	179	111
Sauce dishes	94	117
Dinner plates	37	38
Saucers	52	62
Water pitchers	8	12
Bakers	32	6
Platters	7	3
Gravy boats	2	1
Vegetable dishes	13	16
Cream pitchers	18	6
Vinegar cruets	3	1

During 1931 the total value of broken dishes was $104.98.

MILK REPORT

	1930	1931
Milk, gallons	44,019	48,198½
Buttermilk, quarts	906½	1,635
Cream, quarts	5,053¼	6,895½
Whipping cream, quarts	211¾	252
Sweet butter, pounds	393	466
Cottage cheese, pounds	2,122	2,749

GAS CONSUMPTION

	1930	1931
Main kitchen	$ 587.33	$ 499.60
Diet kitchen	587.33	499.59
Special diet kitchen	120.00	120.00
	$1,294.66	$1,119.19

The personnel of the department as listed in the departmental report was as follows:

Dietitian, assistant dietitian.
First cook, second cook, night cook, diet cooks, 2.
Dishwashers, 3.
Head waitresses, waitresses, 14.
Pastry cook.
Maids, 9.
Orderly, butcher.

Salary payments for 1930 totaled $20,914.05, and for 1931, $21,364.52.

Figuring Laundry Cost

(*Continued from page 48*)

though *you must speak the same language as the other fellow* and that means a standardized system of cost records. Taking the accounts listed above and eliminating those items which we are not concerned with or which the great majority of us are not in a position to obtain accurate records on, we find that the following items constitute legitimate charges against our laundry department:

1. Productive labor.
2. Soap and soda (builder).
3. Bleach, sour (neutralizer), nets and bluing.
4. Starch.
5. General supplies.
6. Aprons, coverings, paddings.
7. Machine repairs and maintenance.
8. Machine depreciation (at 10%).
9. Insurance on equipment.
10. Building repairs and maintenance.
11. Building depreciation.
12. Fire insurance.
13. Rent.
14. Light.
15. Indirect labor.
16. Superintendence.
17. Liability insurance.
18. Miscellaneous indirect expense.
19. Indirect supplies.

By the time that we take these items into consideration we may find that considering only the items of salaries and supplies tells us only half the story.

MRS. BOSWORTH DEAD

Mrs. Valentene R. Bosworth, superintendent of Chicago Memorial Hospital since January, 1920, died October 16 after a brief illness. News of her passing will be a shock to her many friends, for she attended the A. H. A. convention in Milwaukee and also was active in preparing for the A. H. A. institute. Mrs. Bosworth had been associated with the hospital since March, 1915, when it was known as Hahnemann Hospital. She was active in the Chicago and Illinois associations and a familiar figure at many conventions. Miss Josephine Blalock, office manager, was temporarily placed in charge pending a decision by the board.

MISS SNIVELY DEAD

"The Mother of Nursing in Canada," Mary Agnes Snively, first woman superintendent of the Toronto General Hospital and of the Nurses' Training School there, died September 26 in the private pavilion of the hospital which she loved. Miss Snively was in her 86th year.

WHO'S WHO IN HOSPITALS

REV. DR. CHARLES C. JARRELL, president-elect of the Protestant Hospital Association, will enter the office of president of a church hospital group no stranger to its duties and responsibilities since he is the founder and first president of the Methodist Episcopal Church, South, Hospital Association. He has been general secretary of the hospital board of his church since 1923, during which time he has visited the various institutions and has further familiarized himself with church hospital problems by regular attendance at and participation in national and sectional conventions. Dr. Jarrell early attracted attention in the national Prostestant Hospital body by his eloquence and he has been a featured orator at all recent conferences. A distinguished service as teacher in various church educational institutions preceded Dr. Jarrell's entry into hospital work. His educational background includes post-graduate work in Scotland and Germany.

Howard E. Bishop, Packer Hospital, Sayre, Pa., is glad of the fact that his son, Joseph W. Bishop, likes hospital administration and spent the summer under the tutelage of John M. Smith, Hahnemann Hospital, Philadelphia.

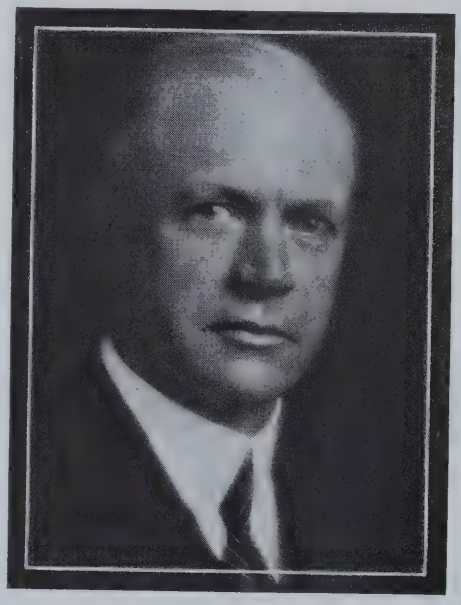
Mary Scheer, R. N., formerly of Grant Hospital, Chicago, has taken the position of principal of the school of nursing of Union Hospital, Terre Haute, Ind. Dorothy James, R. N., formerly of Decatur and Macon County Hospital, Decatur, Ill., is the new instructress. Dr. C. N. Combs is superintendent of the hospital.

Ingra E. Erickson is acting superintendent of nurses of Butterworth Hospital, Grand Rapids, Mich.

Dr. J. E. Daugherty, for many years executive director of the Jewish Hospital, Brooklyn, and an active figure in national and state hospital meetings, recently was appointed superintendent of the Jamaica Hospital, Richmond Hill, New York.

James T. Pate, for three years assistant superintendent of Duke University Hospital, Durham, N. C., on October 2 began his duties as assistant to Reuben O'Brien, superintendent of Manhattan Eye, Ear and Throat Hospital, New York City.

A striking feature of the attendance at the A. H. A. Institute was the registration of five sons of superintendents: Richard Benson, son of Dr. John G. Benson, Methodist Hospital, Indianapolis; Roland G. Fritschel, son of Dr. H. L. Fritschel, Milwaukee, Wis., Hospital; Hugh P. Cooper, son of Hugh A. Cooper, Southwestern Presbyterian Hospital, Albuquerque, N. M.



REV. CHARLES C. JARRELL
Secretary, Hospital Board, M. E. Church, South

(both father and son got diplomas); Thomas A. Hyde, Jr., son of Dr. Hyde, Christ Hospital, Jersey City; Carl P. Wright, Jr., son of Mr. Wright of General Hospital, Syracuse, N. Y. Young Mr. Wright is associated with Dr. Munger at Grasslands Hospital, Valhalla, N. Y., but the other sons are learning hospital administration in their father's hospitals. Neil Jamieson, nephew of Mary A. Jamieson, veteran superintendent of Columbus, O., was another registrant.

Louise Whelpley has resigned as superintendent of Community Hospital, Geneva, O.

Ida C. Smith, who has served the Children's Hospital, Boston, Mass., for 45 years, the last sixteen years as superintendent, resigned recently.

Mary A. Miller was appointed night supervisor of the William H. Coleman Hospital, Indianapolis, Ind.

Mrs. Irene Meyer is the new superintendent of the Municipal Hospital, Reedsburg, Wis., succeeding Edna Larson, who resigned because of ill health.

Emma Bell McClure has assumed her duties as superintendent of the Morristown, Tenn., General Hospital, succeeding Carrie Lee Spencer, who resigned to accept a position as superintendent of the Lee General Hospital, Pennington Gap, Va.

Sister Mary Bernard, who was formerly head of the X-ray and laboratory departments of St. Rita's Hospital, Lima, O., recently was made supervisor, succeeding Sister Mary Blanche, who is assuming similar duties at Mercy Hospital, Toledo.

Lucille Leetch is the new superintendent of Fairbury, Ill., Hospital, succeeding Rachel Olson, resigned.

Maxwell Lewis, business manager of Sydenham Hospital, New York City, on September first assumed complete charge of the management of the institution, succeeding Dr. S. Wachsman, who resigned to resume the practice of medicine.

Eleanor M. Bresnahan, R. N., recently resigned as superintendent of Jefferson Clinic, Detroit, to become general supervisor and anesthetist at the Jackson Memorial Hospital, Miami, Fla.

Charles E. Findlay is the new superintendent of Butterworth Hospital, Grand Rapids, Mich., succeeding Sidney G. Davidson, now in charge of Grace Hospital, New Haven, Conn. Mr. Findlay has been in the field since 1916, beginning as secretary to the dean of the college of medicine of Ohio State University, which conducts Starling-Loving Hospital, Columbus. He gradually advanced to assistant, acting, and finally superintendent of that institution, leaving Columbus in May, 1930, to become superintendent of City Hospital, Springfield, O. During his regime at Springfield Mr. Findlay helped to plan, construct and equip the $1,800,000 plant opened in 1932. Mr. Findlay has been president of the Columbus hospital association and a vice-president of the Ohio association, as well as serving on committees in the state and national bodies. He has contributed a number of articles to HOSPITAL MANAGEMENT and other journals.

Alice H. Otto has resigned as superintendent of nursing at Montefiore Hospital, New York City, Dr. E. M. Bluestone, director, and has been succeeded by Anne C. Donahue, assistant superintendent, during the period of reorganization.

A Technical Library Free to You for the Asking

Some of the best technical brains in the country, long experienced in research directed toward improving products and methods for the hospital field, have contributed to the array of literature listed below. It is carefully and often expensively and beautifully prepared for the purpose of assisting you in your work, and all you have to do is to ask for it. Indicate the numbers of such items as may interest you and we will see that they are sent to you promptly.

Anaesthetics

No. 358, 359, 360. Booklets on "Spinal Anesthesia," "Obstetrical Analgesia" and "Open Ether Anesthesia," authoritatively prepared for the profession by E. R. Squibb & Sons. 233

Cubicle Equipment

No. 337. "Privacy in the Modern Hospital" is the title of a valuable booklet on cubicle screening published by H. L. Judd Co. After outlining the problems involved in securing privacy for ward patients, the booklet works out concrete solutions for many problems. c32

General Equipment, Furnishings and Supplies

No. 364. "The All-Wool Blanket," a booklet giving details of the manufacture and care of wool blankets, bedmaking, etc. Kenwood Mills. 433

No. 370-371. A card showing color samples of blankets, and (371) a card to hang in the laundry showing just how to launder all-wool blankets. Kenwood Mills.

No. 284. "Ten Kinds of Baths." Cannon Mills, Inc. b0

No. 342. A table showing the amount of Lysol disinfectant and water necessary to make solutions of various strength, together with a description of the correct solutions to use for various purposes in the hospital. Also a dilution chart for use in the laundry. Lehn & Fink, Inc. 532

No. 261. "Nurses' Apparel and Hospital Supplies," a 32-page catalog. Marvin-Neitzel Corp.

No. 328. "Curity Ready Made Dressings Manual," an interesting manual showing the complete line of ready made dressings, with descriptions of uses and other informative material. Lewis Mfg. Co. L31.

No. 340. A complete series of pamphlets, many of which, such as "The Mystery of Sleep," "Why the Cat Unit?" and "When Chemists Turned from Gold to Drugs," are especially useful in teaching materia medica to student nurses. Available in any quantity. Hoffman-La Roche, Inc. 432

No. 376. "Wyandotte Products for Hospitals and Institutions" explains how all cleaning in the hospital and institution can be done, and how every rule of thorough, safe and economical cleaning can be easily followed. The J. B. Ford Co., Wyandotte, Mich. 1033

No. 354. Sterilizing technique for rubber gloves, and a description of the "Anode" process of glove manufacture. Massillon Rubber Co. 1033

No. 355. "Surgical Motion Pictures," a folder describing the pictures on clinical subjects available for loan to hospitals. Davis & Geck, Inc. 233

No. 356. "Alcohol Facts," a leaflet describing the various kinds of alcohol and related chemicals used in hospital work. Rossville Commercial Alcohol Corp. 233

No. 366. "Hospital Service Book and Catalog No. 1" has just been issued by Johnson & Johnson, containing editorial and catalog material about surgical dressings, sutures, etc.

No. 367. Free of charge regularly to any hospital executive interested in radiography, "Radiography and Clinical Photography," a magazine published by Eastman Kodak Co. 633

No. 368. The "White Knight" list of quality garments for all hospital purposes, as well as linens and blankets, with prices. Issued by Will Ross, Inc.. 733

No. 369. "Care of All-Wool Blankets," a detailed description of the methods of storing, laundering, cleaning and otherwise caring for wool blankets so as to keep them in good condition. Published by Kenwood Mills. 733

No. 372. A handsomely-illustrated booklet describing in detail Western Electric program distribution systems for hospitals. Graybar Electric Co. 833

No. 373. An authoritative discussion of cleaning problems, "Building Cleanliness Maintenance," in attractive form. Colgate-Palmolive-Peet Co. 833

No. 374. "The Sya-Vac," a non-mechanical evacuating apparatus, just introduced by the Scialytic Corp. 1033

No. 375. "Towels and Their Story," describing manufacture, care and selection of towels for all purposes. Cannon Mills. 1033

Kitchen and Food Service Equipment

No. 363. A booklet giving quantity and individual recipes and analyses of food values of bananas. Issued by the Editorial Department of the United Fruit Co. 433

No. 365. A handsomely printed 84-page booklet of descriptive and catalog information about cooking china, teapots, etc. Hall China Co. 433

No. 349. "Practical Planning for Hospital Food Service," a 62-page booklet published by the John Van Range Co., covering every detail of kitchen and food service planning and equipment. 1032.

No. 351. "Adobe Ware," a beautifully illustrated 12-page booklet describing the newest type of china for general and tray service. Onondaga Pottery Co. 1032.

No. 300. "The Perfect Tray," by Helen E. Gilson, Onandaga Pottery Co. d0

No. 276. Modern Kitchens. A 70-page booklet. International Nickel Company. C30

No. 252. "Scientific Hospital Meal Distribution." Swartzbaugh Mfg. Co., Toledo, O.

Sutures and Ligatures

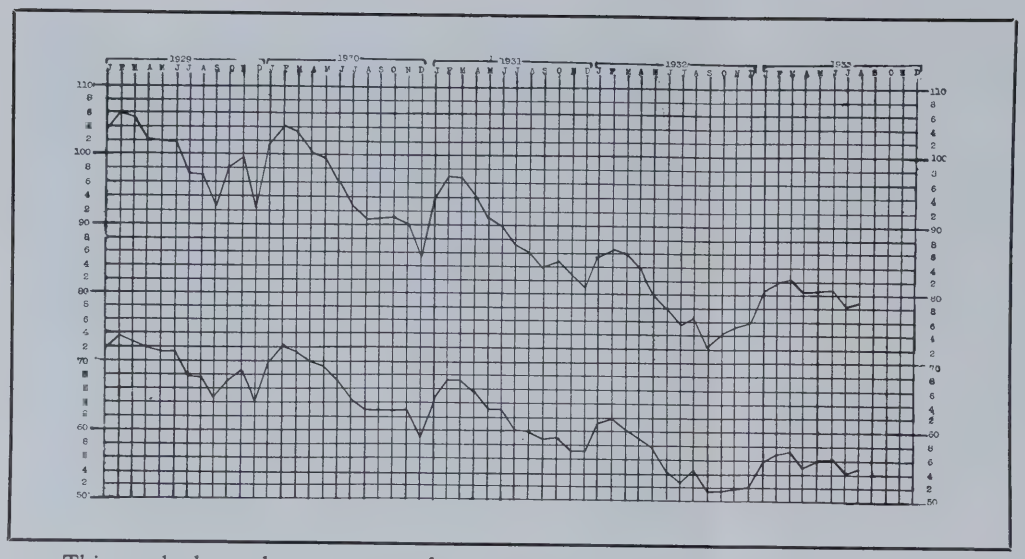
No. 322. "Handbook on Ligatures and Sutures," 1931 edition. An interesting booklet on the history, preparation, handling and use of ligatures and sutures, completely revised. Johnson & Johnson.

No. 361. "Manual of Surgical Sutures and Ligatures," a 56-page description of the manufacturing processes, uses and behavior of all kinds of sutures and ligatures. Published by Davis & Geck. 333

Sterilizers

No. 234. "American Sterilizers and Disinfectors." Catalog. American Sterilizer Company, Erie, Pa.
lets. Wilmot Castle Company.

No. 213. "Sterilizing Technique Series." Five book-



Seasonal drops in occupancy are reflected in the latest figures from the 91 hospitals in 35 states reporting this "How's Business?" data.

This graph shows the percentage of occupancy in 91 general hospitals in 87 communities in 35 states, with a basic bed capacity of 16,922. The upper line is based on the use of average 1929 occupancy as 100 per cent, and the lower line was drawn to show actual percentage of occupancy to normal bed capacity.

"How's Business?"

Total Daily Average Patient Census

January, 1929	11,919
February, 1929	12,335
March, 1929	12,253
April, 1929	12,114
May, 1929	11,981
June, 1929	12,025
July, 1929	11,473
August, 1929	11,548
September, 1929	11,157
October, 1929	11,590
November, 1929	11,736
December, 1929	10,977
January, 1930	12,048
February, 1930	12,425
March, 1930	12,408
April, 1930	12,128
May, 1930	12,044
June, 1930	11,601
July, 1930	11,290
August, 1930	10,997
September, 1930	11,015
October, 1930	11,086
November, 1930	11,005
December, 1930	10,524
January, 1931	11,510
February, 1931	11,991
March, 1931	11,970
April, 1931	11,669
May, 1931	11,251
June, 1931	11,187
July, 1931	10,765
August, 1931	10,657
September, 1931	10,409
October, 1931	10,499
November, 1931	10,266
December, 1931	10,145
January, 1932	10,758
February, 1932	11,038
March, 1932	10,888
April, 1932	10,596
May, 1932	10,082
June, 1932	9,927
July, 1932	9,571
August, 1932	9,748
*September, 1932	9,125
*October, 1932	9,226
*November, 1932	9,328
December, 1932	9,403
January, 1933	10,037
February, 1933	10,197
March, 1933	10,222
April, 1933	9,957
May, 1933	10,004
June, 1933	10,023
July, 1933	9,786
August, 1933	9,809

Receipts from Patients

January, 1929	1,795,843.79
February, 1929	1,776,040.82
March, 1929	2,024,823.11
April, 1929	1,929,175.70
May, 1929	1,920,982.43
June, 1929	1,874,173.11
July, 1929	1,846,899.32
August, 1929	1,867,706.24
September, 1929	1,772,230.39
October, 1929	1,828,051.39
November, 1929	1,786,036.71
December, 1929	1,737,404.65
January, 1930	1,840,418.05
February, 1930	1,799,080.00
March, 1930	2,003,309.58
April, 1930	1,927,493.30
May, 1930	1,921,523.05
June, 1930	1,817,813.00
July, 1930	1,803,315.00
August, 1930	1,719,634.00
September, 1930	1,700,314.00
October, 1930	1,741,017.00
November, 1930	1,640,374.00
December, 1930	1,687,813.00
January, 1931	1,771,812.00
February, 1931	1,720,474.00
March, 1931	1,881,003.00
April, 1931	1,831,228.00
May, 1931	1,815,096.00
June, 1931	1,743,189.00
July, 1931	1,698,277.00
August, 1931	1,598,869.00
September, 1931	1,555,436.00
October, 1931	1,583,005.00
November, 1931	1,497,948.00
December, 1931	1,521,552.00
January, 1932	1,527,159.00
February, 1932	1,468,059.00
March, 1932	1,574,446.00
April, 1932	1,496,077.00
May, 1932	1,453,746.00
June, 1932	1,417,856.00
July, 1932	1,357,096.00
August, 1932	1,327,016.00
September, 1932	1,244,635.00
*October, 1932	1,248,504.00
*November, 1932	1,206,405.00
December, 1932	1,258,672.00
January, 1933	1,331,825.00
February, 1933	1,234,741.00
March, 1933	1,271,784.00
April, 1933	1,284,895.00
May, 1933	1,342,120.00
June, 1933	1,333,867.00
July, 1933	1,290,472.00
August, 1933	1,310,558.00

Operating Expenditures

January, 1929	2,104,552.74
February, 1929	2,007,945.24
March, 1929	2,099,208.11
April, 1929	2,071,386.46
May, 1929	2,064,381.77
June, 1929	2,034,409.13
July, 1929	2,045,112.96
August, 1929	2,068,388.63
September, 1929	2,050,510.38
October, 1929	2,079,042.06
November, 1929	2,091,089.31
December, 1929	2,127,053.36
January, 1930	2,190,909.95
February, 1930	2,067,112.17
March, 1930	2,120,861.86
April, 1930	2,064,328.56
May, 1930	2,102,407.49
June, 1930	2,027,258.00
July, 1930	2,038,042.00
August, 1930	1,985,045.00
September, 1930	2,079,154.00
October, 1930	2,033,163.00
November, 1930	2,003,297.00
December, 1930	2,031,148.00
January, 1931	2,058,681.00
February, 1931	1,963,391.00
March, 1931	2,026,363.00
April, 1931	1,976,430.00
May, 1931	1,967,866.00
June, 1931	1,932,832.00
July, 1931	1,925,156.00
August, 1931	1,870,985.00
September, 1931	1,890,891.00
October, 1931	1,885,424.00
November, 1931	1,829,539.00
December, 1931	1,889,887.00
January, 1932	1,806,279.00
February, 1932	1,763,572.00
March, 1932	1,762,657.00
April, 1932	1,733,486.00
May, 1932	1,672,550.00
June, 1932	1,607,822.00
July, 1932	1,590,274.00
August, 1932	1,565,767.00
*September, 1932	1,508,519.00
*October, 1932	1,515,582.00
*November, 1932	1,488,989.00
December, 1932	1,568,845.00
January, 1933	1,546,747.00
February, 1933	1,490,075.00
March, 1933	1,585,755.00
April, 1933	1,531,870.00
May, 1933	1,536,710.00
June, 1933	1,545,307.00
July, 1933	1,555,554.00
August, 1933	1,555,701.00

Average Occupancy on 100 Per Cent Basis

January, 1929	71.6
February, 1929	73.8
March, 1929	73.2
April, 1929	72.2
May, 1929	71.2
June, 1929	71.3
July, 1929	67.8
August, 1929	67.5
September, 1929	65.0
October, 1929	68.0
November, 1929	68.6
December, 1929	64.0
January, 1930	70.1
February, 1930	72.1
March, 1930	71.8
April, 1930	70.0
May, 1930	69.4
June, 1930	66.6
July, 1930	64.7
August, 1930	62.7
September, 1930	62.8
October, 1930	62.9
November, 1930	62.4
December, 1930	59.1
January, 1931	64.9
February, 1931	67.5
March, 1931	67.2
April, 1931	65.8
May, 1931	63.0
June, 1931	62.6
July, 1931	60.3
August, 1931	59.7
September, 1931	58.3
October, 1931	59.0
November, 1931	57.5
December, 1931	56.8
January, 1932	60.2
February, 1932	61.8
March, 1932	61.0
April, 1932	59.3
May, 1932	56.4
June, 1932	55.6
July, 1932	53.6
August, 1932	54.6
*September, 1932	51.1
*October, 1932	51.6
*November, 1932	52.2
December, 1932	52.6
January, 1933	56.2
February, 1933	57.0
March, 1933	57.2
April, 1933	55.7
May, 1933	56.0
June, 1933	56.1
July, 1933	54.7
August, 1933	54.9

*One hospital closed during construction program.

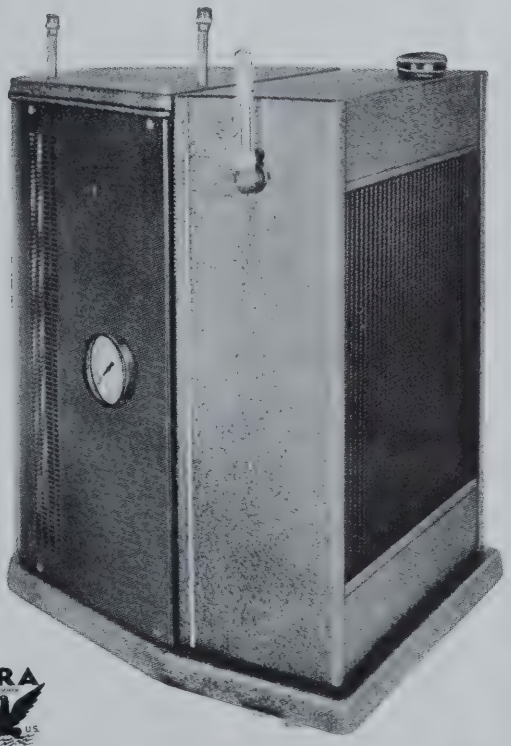
Two more timely developments in deep therapy equipment

—*with which to modernize and increase the therapeutic range of your present facilities*

PRESENT day interest in high voltage x-ray therapy and its widely increasing use is unprecedented. Improvements in apparatus and tubes, delivering much higher x-ray energies with better means of control to insure more accurate measurement of dosage, are contributing to marked advances in this form of therapy. The appreciable advantages realized in their use are too important to overlook.

To roentgenologists who find their present facilities inadequate for the application of the more recently adopted techniques, we suggest that we be given an opportunity to advise with them in the formation of a practical and economical plan of bringing their equipment up to date. Of late, many institutions have availed themselves of this service, with gratifying results.

This announcement refers to only two of a number of major developments in high voltage equipment emanating from our research laboratories within the past year.



XPT-3 Coolidge Tube 300 KV. P.

Embodies the same general principles of construction as in the well known "XP" series of Coolidge diagnostic tubes.

On special order is supplied with x-ray protective cover, with which the intensity of scattered radiation is less than 1% of beam radiation filtered through 1 mm. copper. Also may be purchased without protective cover, for operation in lead lined box or drum of existing equipment.

Ratings:

300 kv. p., 10 ma., continuous } on half or full wave rectified circuit (pulsating current).

200 kv. p., 15 ma., continuous } on half or full wave rectified circuit (pulsating current).

Artificial cooling, by circulation of water or oil through anode. Existing cooling equipment, properly insulated, is readily adaptable.

Oil Cooling System for High Voltage Tubes

By the use of oil instead of water for cooling the target of the x-ray tube, very definite advantages are realized. From the fact that oil in itself is a highly efficient insulator, it is not necessary to mount the entire cooling system on insulators, nor separate the motor, pump, fan and radiator with insulators, as is necessary with a water cooling system. With oil as the cooling medium, operation at ground potential becomes possible. A much more compact construction is also realized, the entire system being enclosed in the cabinet here illustrated, which requires less than four square feet of shelf space.

NRA U.S. WE DO OUR PART

GENERAL ELECTRIC X-RAY CORPORATION

2012 Jackson Blvd. *Formerly Victor X-Ray Corporation* **Chicago, Illinois**

X-RAY; LABORATORIES

Schools for Technicians Listed for Approval

Training schools for clinical laboratory technicians approved in 1933 by the board of registry of technicians, American Society of Clinical Pathologists were listed as follows on a leaflet distributed at the 1933 A. H. A. convention. The name of the director also is given:

Class A.—Entrance prerequisites of 4 years' college work.
Class B.—Entrance prerequisites of 2 years' college work.
Class C.—Entrance prerequisites of 1 year's college work.
Class D.—Regular University or College course.
All including chemistry and biology.

CLASS "A"

Geisinger Memorial Hospital, Danville, Pa., Dr. Henry F. Hunt.
Henry Ford Hospital, Detroit, Michigan, Dr. Frank W. Hartman.
St. Joseph Hospital, Kansas City, Missouri, Dr. Emsley Johnson.
St. John's Hospital, Springfield, Illinois, Dr. Walter G. Bain.
Mt. Zion Hospital, San Francisco, California, Dr. Charles Weiss.
Minneapolis General, Minneapolis, Minn., Dr. N. H. Lufkin.
Buffalo General, Buffalo, New York, Dr. Byron D. Bowens.

CLASS "B"

Ancker Hospital, St. Paul, Minnesota, Dr. John F. Noble.
Stuart Circle Hospital, Richmond, Va., Dr. Regina C. Beck.
University Hospital, Omaha, Nebraska, Dr. J. P. Tollman.
St. Mary's Hospital, Duluth, Minnesota, Dr. G. Berdez.

CLASS "C"

St. John's Hospital, Brooklyn, New York, Dr. Theo. J. Curphey.
Mercy Hospital, Baltimore, Maryland, Dr. H. T. Collenberg.
Presbyterian Hospital, Denver, Colorado, Dr. P. C. Carson.
St. Luke's Hospital, Spokane, Washington, Dr. R. F. E. Stier.
Temple Univ. Hosp., Philadelphia, Pa., Dr. F. W. Konzelmann.
Sacred Heart Hospital, Spokane, Washington, Dr. M. M. Potter.
The Grace Hospital, Detroit, Michigan, Dr. C. I. Owens.
Mt. Sinai Hospital, Cleveland, Ohio, Dr. B. S. Klein.
Beth Israel Hospital, Newark, N. J., Dr. Asher Yaguda.
Wisconsin General Hospital, Madison, Wis., Dr. W. D. Stovall.
*Monmouth Memorial Hosp., Long Branch, N. J., Dr. C. A. Pons.
Swedish Hospital, Minneapolis, Minnesota, Dr. C. D. Drake.
Research Hospital, Kansas City, Missouri, Dr. F. C. Narr.
Jefferson Hospital, Philadelphia, Pa., Dr. B. L. Crawford.
The Charles T. Miller Hospital, St. Paul, Minn., Dr. Kano Ikeda.
Uniontown Hospital, Uniontown, Pa., Dr. H. A. Heise.
St. Joseph Hospital, Lexington, Kentucky, Dr. E. S. Maxwell.
St. Joseph Hospital, Louisville, Kentucky, Dr. H. M. Weeter.
Mt. Sinai Hospital, Chicago, Illinois, Dr. I. Davidsohn.
Leila Y. Post Montgomery Hospital, Battle Creek, Mich., Dr. A. A. Humphrey.
*University of Pennsylvania, Phila., Pa., Dr. Herbert Fox.
Mt. Sinai Hospital, Philadelphia, Pa., Dr. D. R. Meranze.
Mercy Hospital, Bay City, Mich., Dr. W. G. Gamble.

CLASS "D"

Emory University, Emory University, Georgia, Dr. Roy R. Kracke.
Michigan State College of Arigculture, East Lansing, Mich., Dr. Ward Giltner.
North Carolina College for Women, Greensboro, N. C., Dr. Lila B. Love.
University of Denver, Denver, Colorado, Dr. E. A. Engle.
Simmons College, Boston, Mass., Dr. C. M. Hilliard.
University of Kentucky, Lexington, Ky., Dr. M. Scherago.
Ohio University, Athens, Ohio, Dr. F. H. Krecker.

THE HOSPITAL CALENDAR

Kansas Hospital Association, Eldorado, October.
Saskatchewan Hosptial Association, Saskatoon, October.
Ontario United Hospital Aids Association, Toronto, October 25.
Ontario Hospital Association, Toronto, October 25-27.
Alberta Hospital Association, November.
Washington State Hospital Conference, Seattle, November 18.
Ohio Hospital Association, Cincinnati, April, 1934.
American Hospital Association, Philadelphia, 1934.
Protestant Hospital Association, Philadelphia, 1934.

*Temporarily discontinued.

New York City's Central Statistical Bureau

By Caroline R. Martin, M. D.
Director, Central Medical Statistical Bureau, New York City Department of Hospitals, New York.

THE Central Medical Statistical Bureau of the New York City Department of Hospitals is a clearing house for data represented by the case histories of all in-patients of the 26 hospitals administered by the City of New York. It was established in order to simplify research and to obtain medical statistics on a quantitative as well as on a qualitative basis.

The preparatory work included—

Adoption of a standard guide for the making of physical examinations and the writing of clinical histories.

Use of a standardized nomenclature. (The Bellevue nomenclature.)

A modified unit history system was installed.

Graduate nurses were trained as historians.

Cooperation of the medical staffs obtained by various means.

Codes were developed to permit the use of a mechanical cross-index.

The system works in the following manner: Each hospital summarizes its case histories on code sheets, of which there is one or more for every disease. The sheets become a diagnostic index to the original charts which are filed in numerical order. Periodically the Central Bureau "borrows" the sheets and, by means of punched holes, transfers the information to tabulating cards.

Electric machines are used to read the cards and to sort them, at tremendous speeds, into any desired classification. Multiple posting is thus made unnecessary.

Comparative analyses, covering large numbers of cases, are made of the causes and manifestations of disease; of the results of different methods of treatment; of operating technique; of laboratory and X-ray procedures; of systems in various administrative departments.

The physical effects of heredity, environment, habit, etc., are studied, with the view of getting preventive data. By this means increased efficiency is obtained in the care of the sick, as well as in administrative routine.

Summary of paper before 1933 A. H. A. convention.

Although the entire method has been in operation only a few years, a number of detailed studies have been made including the following:

Twelve hundred (1,200) cases of malignancy with result of treatment by operation, radium, X-ray, alone and combined.

Two thousand (2,000) cases of poliomyelitis, with findings, and result of treatment with and without serum, a detailed study of Respirator cases with report of semi-annual follow-up.

Four thousand (4,000) cases of lobar pneumonia treated with and without serum, result of serum cases by type of organism and type of serum given.

One thousand, one hundred and forty-seven (1,147) cases of diabetes mellitus.

Eight hundred (800) cases of arthritis, result with and without vaccines.

Six hundred (600) diseases of the gallbladder with tests, operations, treatments and results.

Numerous other studies have been done.

Post-operative pneumonias, infections and other complications developed in hospital, especially those on Surgery, Pediatrics and Obstetrics have been analyzed as to cause, result to patients, and increase in total patients days.

An annual comparison, by hospitals, on mortality rates of mothers and newborns, with analyses of complications, and a follow-up.

Variation in number of laboratory and X-ray procedures, in ratio to admissions in active general hospitals.

The effectiveness of varied operative technique for similar conditions, for example, different methods of doing Caesarian sections: classical, high, medium and low; Latzko's and low-flap operation.

The plan I have outlined to you has been reasonably successful and, therefore, may be considered as a workable basis for the formation of a national service, comprising not only in-patients, but clinics as well. The desirability of a country-wide standardized, correlated method for collecting data has always been recognized by the medical profession. The Department of Hospitals is now giving public recognition to a plan to make it possible.

MEET AT PASADENA

Taking the new "Standard Nomenclature of Diseases" as her subject, Mrs. C. E. Tibbetts addressed representatives of 22 hospitals at the Pasadena Hospital, Pasadena, Calif., September 19 for the first meeting of the year of the Association of Medical Record Librarians of Southern California. Much interest was manifested in this new nomenclature.

An open forum was held on questions of insurance and other problems.

Mrs. Jessie O. Beem, president, conducted the business meeting and gave a very inspiring talk, asking each one to have her part in carrying out the work that the association has outlined for the year. The required number of memberships was taken out to insure a section in the Western Hospital Association.

Guests were Miss L. Prall, new superintendent of Seaside Hospital, Long Beach, and Miss M. Fossler of the New York City Library.

HOSPITAL EXHIBITORS' ASSOCIATION

The commercial exhibitors at the Milwaukee convention, nearly all of whom are members of the Hospital Exhibitors' Association, not only contributed by their presence to the interest and value of the meeting, but topped off the week with one of the most enjoyable parties convention visitors have ever attended. The affair, a supper-dance, was held at the Hotel Plankinton, where the exhibitors' organization had its headquarters, and over 300 persons enjoyed an elaborate floor show, with dance music by a large orchestra, supper at midnight and more dancing. The proceedings were broadcast, and radio listeners at four in the morning were informed that the party was still in progress. Numerous hospital people were entertained by their friends among the exhibitors, and the success of the party was one of the most pleasant events of the week.

Preceding the festivities the organization held its annual business meeting. The election ballots, which had been sent out by mail in advance of the meeting, were counted, and following the [illegible] of Vice President Fred Wilson to accept the presidency, President Wallace Morton was re-elected, Mr. Wilson retaining the vice presidency. Lawrence Davis and E. E. Dickson were elected directors, and Edw. Johnson and Thomas Rudisill, both former presidents, were made trustees. The full staff of officers and directors is now as follows:

Wallace M. Morton, Columbia Feather Company, Chicago, President.

Fred J. Wilson, Wilson Rubber Company, Canton, Ohio, Vice President.

Logan M. Eldredge, Ad. Seidel & Sons, Chicago, Secretary and Treasurer.

Trustees: Edward Johnson, Meinecke & Company, New York, N. Y., and T. J. Rudisill, Scanlan-Morris Company, Madison, Wisconsin.

Directors: Lawrence Davis, Lewis Manufacturing Company, Walpole, Mass.; E. E. Dickson, Johnson & Johnson, Inc., New Brunswick, N. J., and F. L. Marvin, Becton, Dickinson & Company, Rutherford, N. J.

NURSING SERVICE

Dismissal of Patient

[This material is taken from a series of mimeographed instructions governing nursing procedures of Columbia Hospital, Milwaukee, Wis. Other procedures appeared in previous issues, and additional instructions will be found in subsequent issues.]

Last impressions are apt to be lasting.
Order for dismissal must be written.

Dressing the Patient

Get clothes from locker, check in clothes book, write in clothes book "received" date, and have patient sign. See that they have everything that was brought in on entrance. If anything in safe, ask for receipt and take to office and withdraw valuables. If going on Sunday, get valuables on Saturday. Be sure that table drawer, locker and dresser are empty. Send drugs not cancelled with patient; instruct as to how they are to be taken. See that clothing is sufficient. Assist in dressing if necessary; protect with screen if in ward.

Dismissal

If weak, use chair to take patient to front door. Do not let patient make decision. Always accompany to door. See that they are properly escorted from hospital and that they have a definite place to go. Ask operator to call taxi if desired.

Stop at cashier's desk and tell who is leaving.

Leave dismissal slip in T. S. O. If patient has had a special diet, leave slip in dietitian's office also. Put on slip:

Room No.....
Patient's name .....
Dismissed—time .....
Doctor's name..... Nurse's initials.....

Ambulance Cases

Ambulance ordered through office. Have patient and belongings ready for time ambulance is called.

Closing Chart

Cancel orders.

On notes give time of dismissal, how and where (charting number).

On temperature sheet write "Dismissed" from 110 pulse space up, in next temperature column.

On top sheet fill in number of days in hospital and date of discharge. Take out of folder and place on supervisor's desk.

Dismissed Against Advice

If patient insists on going contrary to doctor's advice, slip must be signed.

All head injury cases required to stay at least 24 hours or sign this slip.

Those who walk out under some petty grievance must be required to sign slip.

Care of Room After Dismissal

Equipment—

Pail of soapy water to which is added 30 cc. of lysol.
Cleaning cloths.
Whisk broom.
Bon Ami.
Newspaper.

Procedure—

Strip linen from bed and discard everything.

Dampen whisk broom in lysol solution; sprinkle on mattress and brush all sides thoroughly. Wash off draw sheet and hang over back of chair. Other rubber goods used to be cared for in same way. Brush pillows and place on mattress.

Go over bed and other furniture with solution. Use Bon Ami on bed and cabinet. Wash inside dresser drawers and put in fresh paper.

Carry all utensils to utility room, scour and sterilize.

Inspect mattress and pillows and draw sheet—put out on porch if time permits.

Allow room to air as long as possible. Floor taken care of by floor maid.

Make bed up freshly. Replace utensils in cabinet.

Note—

In infectious cases special care is taken of the walls and floor and room unoccupied for 48 hours.

THE HOSPITAL ROUND TABLE

Card Tells Needs

Philip Vollmer, Jr., superintendent, Fairview Hospital, Cleveland, O., has a card which is sent to supporters of the institution whenever there is occasion to write to them, to churches, board members and others. Mr. Vollmer believes it is most effective in stimulating an appreciation of the financial difficulties of the hospital in trying to meet demands for care of worthy free patients. The card is 3½ by 6½ inches and contains the following:

FREE SERVICE TO THE SICK POOR. PLEASE WRITE.

FAIRVIEW PARK HOSPITAL
3305 Franklin Blvd., Cleveland, Ohio
Twelve months, ending June 30, 1933

Cost of free patients	$19,389.80
Loss on part pay patients	3,326.76
Complimentary discounts to society members, ministers, physicians, nurses	3,273.44
Dispensary deficit	5,232.76
Total	$31,222.76
Received from Welfare Federation	878.45
Total free service for which we were not paid	$30,344.31

WE DEPEND ON DIRECT GIFTS BECAUSE WE RECEIVE NOTHING FROM THE BENEVOLENT FUNDS OF THE CHURCH. PLEASE GIVE.

Signing for Autopsy

Among the numerous interesting and practical discussions at the A. H. A. institute at the University of Chicago was one relating to the value of a signature of a patient on a permit for autopsy. Dean Spencer, of the university law school, who was asked to discuss this question, stated that the patient's signed permission for an autopsy on his own body was valueless if the nearest relative objected, and that it was necessary to get the husband, wife or nearest relative to sign such a permission before legal liability would be avoided in the case of a dispute. This was a comment of great interest, especially since some hospitals have felt that the permission of a patient was all that was necessary and that such permission outweighed signatures of anybody else.

Unusual Report

"A Small Hospital in a Big Depression" is the title of the annual report of West Side Hospital, New York City, George Rebush, superintendent, which suggests what may be done in getting interesting facts before the community via a mimeographed leaflet. The text of the report is only four pages, 6 by 9, but there also is a list of trustees and the staff of two pages of condensed financial statistics. This hospital, only 27 beds, is one of the smallest on the approved list of the American College of Surgeons. It has completed 60 years of service in the eastern metropolis.

Processing Taxes

C. H. Dabbs, superintendent, Tuomey Hospital, Sumter, S. C., recently received the following information from Washington regarding process tax on wheat:

Reference is made to your letter requesting a decision as to whether or not hospitals organized essentially for charitable purposes and treating 62 per cent of all patients free are subject to the wheat products tax.

Section 9(a) of the Agricultural Adjustment Act provides for the imposition of a processing tax upon the first domestic processing of wheat, and Section 16(a) (1) of the same Act provides that on the date the processing tax becomes effective with respect to wheat there shall also be imposed a tax on floor stocks of articles which, on that date, have already been processed wholly or in chief value from wheat and which are on that date held by any person for sale or other disposition. It is assumed that your inquiry relates to the tax on floor stocks.

Inasmuch as you are not holding the goods for sale or other disposition within the meaning of the Act, you are not liable for the tax imposed by Section 16(a) (1).

The letter was signed by D. S. Bliss, acting deputy commissioner.

Simplifies Uniform

In his paper read at the Protestant Hospital Association Convention and published on page 26, Carroll H. Lewis, Christ Hospital, Cincinnati, refers to the simplification of nurses' uniforms as a practical economy. The following additional comments were made by Mr. Lewis, in answer to a letter:

"The changes which we made in our students' uniforms were to eliminate a lot of the gathered goods around the waist. In fact, we cut the amount of dress goods in the uniform in half by eliminating the gathering which besides using up too much material necessitated hand ironing because the pleats and gathers were so close together that it could not be done on a flat work ironer. All of the changes that we made in the uniform looked toward preparing the garment to be ironed on a flat work ironer. We eliminated four hand ironers in our laundry at the time that we made this change.

"Also, we changed the fichu which had been hand ironed to a flat type which could also go through the flat work ironer as the rest of the dress. Incidentally we saved on material in the apron and the expense of making the fichu by these maneuvers."

Central Food Service

During the course of lectures at the A. H. A. institute at the University of Chicago, Perry Swern, hospital architect, in discussing the advantages of central food service versus floor pantry service, asserted that at one time a study was made of two 300-bed hospitals, one with trays set up completely in the main kitchen, and the other with the trays set up from floor pantries. The comparable personnel of the two institutions, as far as the service of food was concerned, he said, was eight for the central food service plan and 36 for the plan under which the handling of food trucks and trays in floor pantries was required.

Food Economies

Elizabeth Hennecke, dietitian, Presbyterian Hospital, Chicago, in a talk on food service economies at the A. H. A. institute suggested that savings could be made if an expensive dessert were used with a meal in which economical foodstuffs formed the menu. She also suggested that it was a good idea to vary the desserts at a given meal in order not to overload the capacity of certain equipment or to put too great a burden on certain employes. For instance, she suggested, salad makers could be relieved of some of their duties if bakery goods were used as dessert for part of the patients and personnel, instead of serving salads to everyone. Such a variation of desserts also would relieve the strain on equipment.

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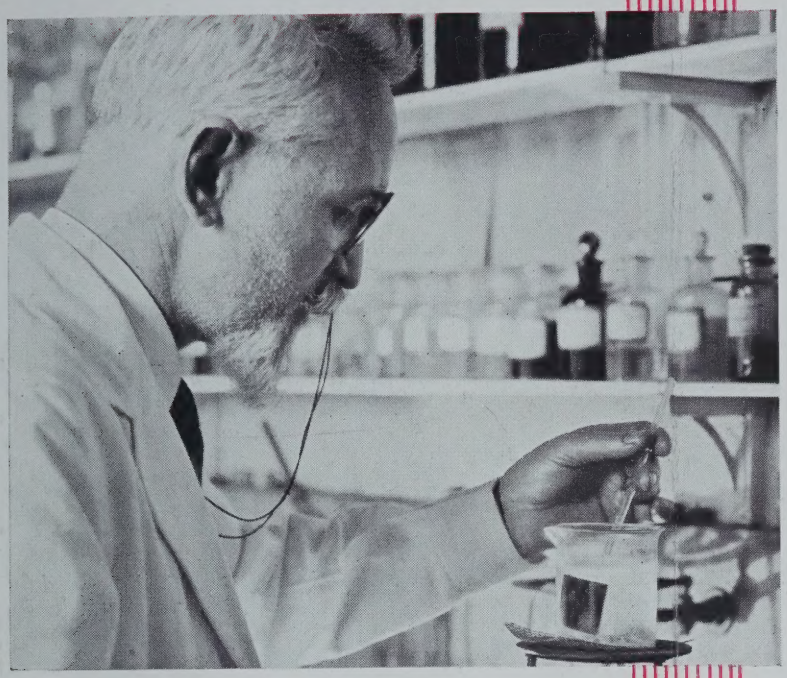

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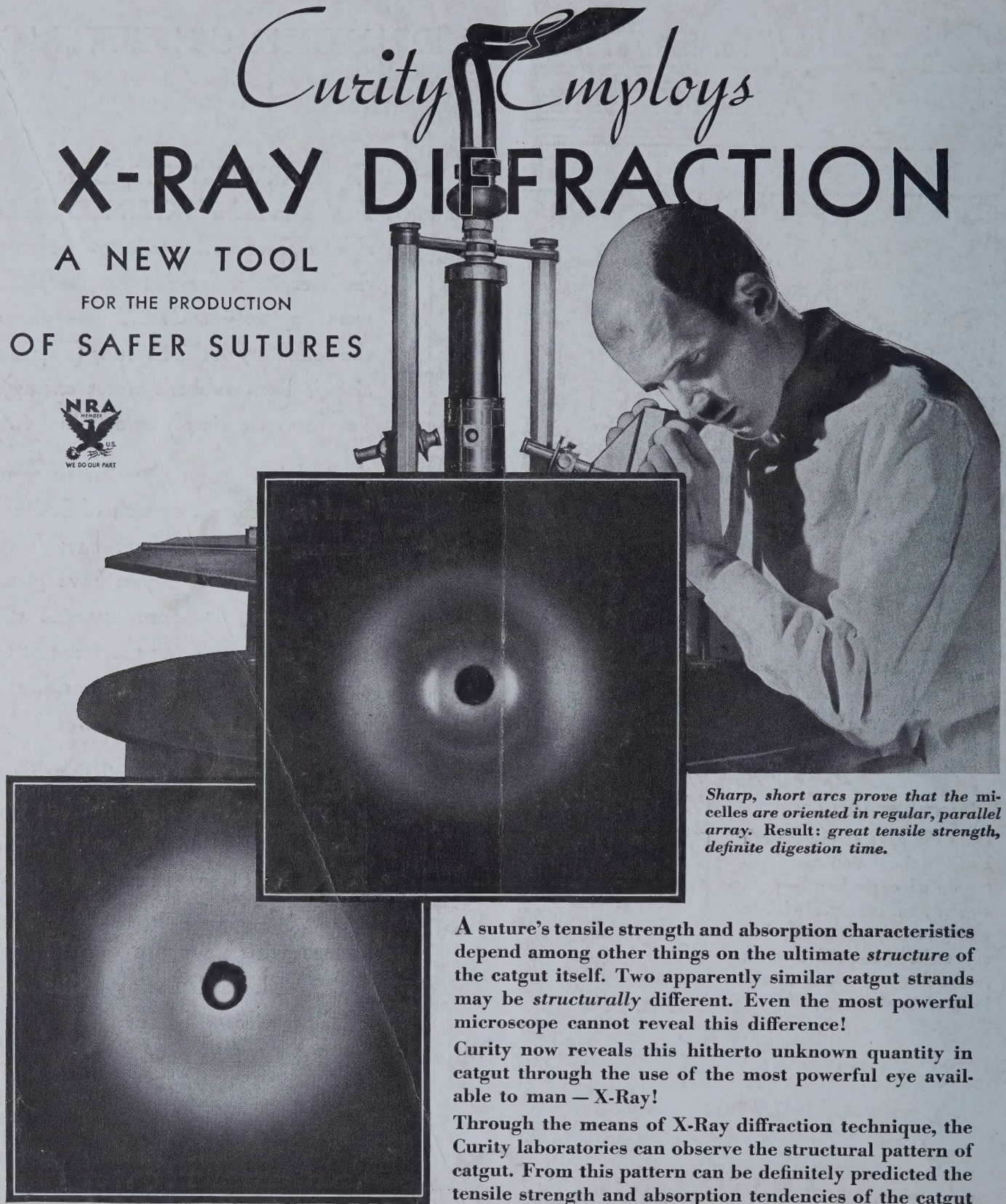

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